AMERICAN LEGISLATIVE EXCHANGE COUNCIL

MEMORANDUM

TO: HEALTH AND HUMAN SERVICES TASK FORCE MEMBERS

FROM: CHRISTIE HERRERA, HHS TASK FORCE DIRECTOR

RE: 35-DAY MAILING—HHS TASK FORCE MEETING AT ALEC'S 37TH ANNUAL MEETING, SAN DIEGO, CA

DATE: JULY 1, 2010

Overview of HHS Activities at ALEC's 37th Annual Meeting

The American Legislative Exchange Council will hold its 37th Annual Meeting from August 5-7 at the Manchester Grand Hyatt in San Diego. An Annual Meeting agenda and registration page are now online, and the cutoff for both registration and housing is Monday, July 12.

Please "save the date" for the following HHS activities at ALEC's 37th Annual Meeting:

Thursday, August 5, 2010
9:15-11:15 a.m.
Health Care Reform: Repeal vs. Implementation
What State Legislators Need to Know

Join nationally-renowned health policy experts as they discuss the latest with the federal health reform law—including implementation timelines, prospects for repeal, and how state legislators can fight back with free-market reforms. All ALEC Annual Meeting attendees are invited to participate in this important discussion.

MODERATOR: Linda Upmeyer, District 12, Iowa House of Representatives

SPEAKERS: Nina Owcharenko, Director, Center for Health Policy Studies, The Heritage Foundation; Michael Cannon, Director of Health Policy Studies, The Cato Institute (*); Tarren Bragdon, President & CEO, Maine Heritage Policy Center (*); J.P. Wieske, Executive Director, Council for Affordable Health Insurance

2:30-3:45 p.m.
Workshop #3
Prescription Drug Abuse: Good Medicines, Bad Behavior

More than 52 million Americans over the age of 12 have taken a prescription medicine for a non-medical use—over 20 percent of the population. Prescription medicines are the second most commonly abused illicit drug. Every day, 2,500 teens abuse a prescription medicine for the first time and this behavior is most common among the 18-25 year old population.

Even though the media publicizes the recent celebrity deaths of Heath Ledger, Anna Nicole Smith, Michael Jackson, Corey Haim and others, it continues to happen in our own backyards. Lawmakers must be aware of this dangerous behavior and be able to guide their constituents to organizations that are working hard to raise awareness about this dangerous behavior.

This panel will feature stakeholders and advocates who have developed "best practices" and potential solutions that could be used in your community. Your constituents, regardless of age, should know about the dangers of misuse and abuse of prescription medications because it could save lives.

MODERATOR: Nancy Spence, District 27, Colorado Senate

SPEAKERS: Sharon Brigner, Deputy Vice President, PhRMA; Steve Pasierb, President and CEO, Partnership for a Drug Free America; Angelo M. Valente, Chief Executive Officer, The American Medicine Chest Challenge

Friday, August 6, 2010
8:00-9:15 a.m.
Plenary Breakfast

SPEAKERS: Greg Babe, President and CEO, Bayer Corporation; Hon. Joe Manchin, Governor, State of West Virginia

11:00 a.m.-12:15 p.m.
Workshop #10
The Tenth Amendment: Federalism and Restoring State Sovereignty

Eighty percent of Americans do not trust the federal government, and that suspicion is growing as Washington continues to step outside of its constitutional limits. Federally mandated health care, bailouts of failing companies and a national debt that is spiraling rapidly out of control are only the most dramatic and recent symptoms of the national government's unconstitutional power grab.

Our panel, consisting of state attorneys general and a federalism expert, will explore: the history and importance of the Tenth Amendment; the erosion of state and individual rights; state efforts to restore the proper balance between the national and state governments; and how the information age can herald in what Representative Rob Bishop of Utah referred to as a Golden Age of Federalism. As federalism is one of ALEC's guiding principles, there is no other topic more fundamental to our work than this one.

MODERATOR: Merrill Matthews, Resident Scholar, Institute for Policy Innovation

SPEAKERS: Hon. Henry McMaster, Attorney General, State of South Carolina; Hon. Rob McKenna, Attorney General, State of Washington (*); Hon. Tom Corbett, Attorney General, Commonwealth of Pennsylvania (*)

12:30-2:15 p.m.
Plenary Luncheon

SPEAKER: Lynn Salo, Vice President, Allergan Medical U.S. Breast Aesthetics Division

Saturday, August 7, 2010
8:00-9:15 a.m.
Plenary Breakfast (sponsored by Pfizer)

9:30 a.m.-12:30 p.m.
HHS Task Force Meeting

ALEC's Health and Human Services Task Force will meet to discuss a number of health reform initiatives, including the role ALEC's medical malpractice models played in the health reform debate; the latest on ALEC's *Freedom of Choice in Health Care Act*; and the evolution of third-party payment in health care. A number of proposed ALEC model bills will be considered, including legislation on free-market Medicaid reform and resolutions on point-of-service reimbursement, medication therapy management, and Medicaid long-term care reform.

(*) – invited

About This Mailing
In addition to this electronic-only 35-Day Mailing, all materials can be accessed online at the HHS Task Force Member Area on ALEC's website. Once you are logged in, click the "HHS 35 Day Mailing AM 2010" document to find the 35-Day Mailing in one complete PDF, or click on the "2010 Annual Meeting" folder to access the mailing's individual documents.

Keep in mind that you will need your ALEC username and password to access the 35-Day Mailing online. Conversely, if you choose to receive 35-Day Mailings via "snail mail," please contact Monica Mastracco at 202-742-8525 or at mmastracco@alec.org. We will assume that you prefer the 35-Day Mailing e-mailed to you unless you indicate otherwise.

Enclosed Materials
Please find the following HHS briefing materials enclosed for ALEC's 37th Annual Meeting:

- Faxable registration form for ALEC's 37th Annual Meeting
- Agenda-At-A-Glance for ALEC's 37th Annual Meeting
- Tentative Agenda for the HHS Task Force Meeting
- Potential Model Legislation (bill order determined by date/time of submission):
  - *Resolution on Point-of-Service Reimbursement*, sponsored by MedImmune's Libby Brunsvold
  - *Patients First Medicaid Reform Act*, sponsored by John Locke Foundation's Joe Coletti
  - *Medication Therapy Management Services Act*, sponsored by GlaxoSmithKline's Gaspar Laca and North Carolina Representative Jeff Barnhart (plus supplemental materials)
  - *Resolution on Improving Quality and Lowering Costs for States Through Medicaid Managed Care*, sponsored by Georgia Senator Renee Unterman
- HHS Task Force Roster
- Draft Minutes from the HHS Task Force Meeting at ALEC's 2010 Spring Task Force Summit
- ALEC's Mission Statement/Scholarship Policy by Meeting/Task Force Operating Procedures

Questions?
I look forward to seeing everyone in San Diego. If you have any questions or comments regarding the meeting, please contact me at (202) 742-8505 or at christie@alec.org. Thank you for all you do to make ALEC a great organization for great health care policy!

ATTENDEE
REGISTRATION / HOUSING FORM

American Legislative Exchange Council

Early registration deadline: June 23, 2010
Standard registration deadline: July 12, 2010
Housing cut-off date: July 12, 2010

Manchester Grand Hyatt – San Diego, CA

Online www.alec.org | **Fax** *(credit cards only)* 202.331.1344 | **Phone / Questions** • Mon-Fri, 9am-5:30 pm Eastern 202.742.8538 | **Mail** • ALEC Registration & Housing P.O. Box 96754 • Washington, DC 20090–6754

ATTENDEE INFORMATION

Prefix *(required)* ☐ Sen ☐ Rep ☐ Del ☐ Mr ☐ Mrs ☐ Ms ☐ Other _____

Last Name _____ First Name _____ Middle Initial _____ Badge Nickname _____

Title _____

Organization *(required)* _____

Address _____ Suite # _____

City _____ State/Province _____ Country _____ ZIP/Postal code _____

Daytime phone _____ Fax _____ Alternate phone _____

Email *(confirmation will be sent by email)* _____

Spouse / Guest / Kids' Congress: Please complete the Spouse / Guest / Kids' Congress registration form.

REGISTRATION INFORMATION

****Save $100 on registration by booking your hotel room in ALEC's headquarter hotel****

DISCOUNTED REGISTRATION FEES are extended only to registrants booking in ALEC's headquarter hotel. Your $100 savings will become valid when accommodations are confirmed.

☐ I am already registered: Order # _____

*** Please note that member fees are subject to verification*

	EARLY until June 23	*STANDARD until July 12*	*ON-SITE begin July 13*	*DAILY*	*Amount*
☐ ALEC Legislative Member	$510	$610	$710	$395	$ _____
☐ Legislator / Non-Member	$625	$700	$850	$495	$ _____
☐ ALEC Private Sector Member	$840	$1090	$1800	$895	$ _____
☐ Private Sector / Non-Member	$1075	$1725	$2200	$1095	$ _____
☐ ALEC Non-Profit Member (501(c)(3) status required)	$615	$740	$940	$595	$ _____
☐ Non-Profit Non-Member (501(c)(3) status required)	$750	$950	$1150	$795	$ _____
☐ Legislative Staff / Government	$685	$785	$935	$595	$ _____
☐ ALEC Legacy Member	$0	$0	$0	$0	

Promo Code _____ **TOTAL REGISTRATION FEES:** **$** _____

METHOD OF REGISTRATION PAYMENT

Credit Card: Credit cards will be charged immediately. Please fax to the above number for processing.

☐ Amer Express ☐ Visa ☐ MasterCard

Card # _____

Cardholder *(please print)* _____

Exp Date *(mm/yy)* _____ Security Code_____

Signature _____

Checks: Payment must be in U.S. currency drawn on a U.S. bank. Please make check payable to ALEC Registration and send to above address.

Note: Registration forms with enclosed payments must be received by 5pm Eastern on the following dates to be eligible for discounted registration rates: June 9, 2010, for early registration rates, or July 12, 2010, for standard registration rates. Forms and/or payments received beginning July 13, 2010, will be subject to the on-site registration rate. If registering after July 13, 2010, please bring completed form and payment to register on-site.

REGISTRATION CONFIRMATION INFORMATION

Online registrants will receive immediate email confirmation. If registering by form, confirmation will be emailed, faxed, or mailed within 72 hours of receipt of payment.

REGISTRATION CANCELLATION / REFUND INFORMATION

Registrations cancelled prior to 5pm Eastern July 12, 2010 are subject to a $100 cancellation fee. Registrations are non-refundable after 5pm Eastern July 12, 2010.

HOUSING — RESERVATION CUTOFF FOR ALEC DISCOUNTED RATE IS 12pm Eastern July 12, 2010

****Save $100 on registration by booking your hotel room in ALEC's headquarter hotel****

☐ I do not require a reservation at this time.

Arrival Date _____ **Departure Date** _____

☐ Sharing room with _____

Room type

☐ Single	(1 person–1 bed)	$ 219
☐ Double	(2 persons–1 bed)	$ 239
☐ Dbl/Dbl	(2 persons–2 beds)	$ 239
☐ Triple	(3 persons–2 beds)	$ 259
☐ Quad	(4 persons–2 beds)	$ 259

Note: All rates DO NOT include sales tax *12.71% (subject to change)*

A limited number of **suites** are available upon request. Please call (800) 221-3531 for additional information.

Special requests

☐ ADA room required:
___ Audio ___ Visual ___ Mobile

☐ Rollaway / crib: _____

☐ Other:

_____

_____

METHOD OF HOUSING PAYMENT

☐ Please use the same method of payment as above.

Credit Card: Credit cards will be used to guarantee the reservation

☐ Amer Express ☐ Visa ☐ MasterCard ☐ Discover

Card # _____

Cardholder *(please print)* _____

Exp Date *(mm/yy)* _____ Security Code_____

Signature _____

Checks: Payment must be in U.S. currency drawn on a U.S. bank. Please make check payable to ALEC and send to above address.

HOUSING CONFIRMATION INFORMATION

Online reservations will receive immediate email confirmation. Reservations received by form will be confirmed via email, fax, or mail within 72 hours of receipt.

HOUSING CANCELLATION / REFUND INFORMATION

Credit cards will be charged one night room and tax in the event of a no show or if cancellation occurs within 72 hours prior to arrival. Departures prior to the departure date confirmed by the hotel at check-in will result in a charge of $100. Please obtain a cancellation number when your reservation is cancelled.

Agenda

Tuesday, August 3, 2010

Board of Directors Reception, *by invitation only*	6:30 p.m. - 7:30 p.m.	Off-site
Board of Directors Dinner, *by invitation only*	7:30 p.m. - 9:30 p.m.	Off-site

Wednesday, August 4, 2010

Registration Open	12:00 p.m. - 5:00 p.m.	Litrenta Foyer
Joint Board of Directors Meeting	9:00 a.m. - 5:30 p.m.	Elizabeth FG
State Chairs Training Session	2:00 p.m. - 5:00 p.m.	Del Mar AB
NCHL Working Group	3:00 p.m. - 5:00 p.m.	Madeline ABC
Leadership Reception, *by invitation only*	6:00 p.m. - 7:00 p.m.	Elizabeth Foyer
Leadership Dinner, *by invitation only* *Sponsored by Reynolds American* *Speaker: Ms. Susan Ivey, Chairman, President and CEO, Reynolds American*	7:00 p.m. - 9:00 p.m.	Elizabeth GH
Hospitality Suite	9:00 p.m. - 11:00 p.m.	Madeline ABC

Thursday, August 5, 2010

Registration Open	7:30 a.m. - 5:00 p.m.	Litrenta Foyer
State Chairs Meeting	9:00 a.m. - 11:15 a.m.	Elizabeth F
Task Force: International Relations	9:00 a.m. - 11:15 a.m.	**Manchester H, I**
ALEC Exhibition Hall Open	8:00 a.m. - 5:00 p.m.	Elizabeth ABCDE
Attendee Grab-N-Go Breakfast	8:00 a.m. - 11:15 a.m.	Elizabeth ABCDE
Task Force Working Groups and Subcommittees	8:00 a.m. - 11:15 a.m.	
Fiscal Federalism Working Group	8:00 a.m. - 9:00 a.m.	Elizabeth G
Environmental Health Working Group	8:00 a.m. - 9:30 a.m.	Manchester G
Transportation Subcommittee	9:00 a.m. - 10:00 a.m.	Elizabeth H
Leadership Institute: New Media Workshop	9:00 a.m. - 11:15 a.m.	George Bush
Public Pension Reform Working Group	9:15 a.m. - 10:15 a.m.	Elizabeth G
Health Care Reform: Repeal vs. Implementation	9:15 a.m. - 11:15 a.m.	Mohsen AB
Energy Subcommittee	10:00 a.m. - 11:15 a.m.	Manchester G

Agenda

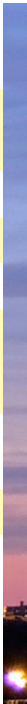
Working Group on Education Reform	10:00 a.m. - 11:15 a.m.	Madeline AB
Corrections and Reentry Working Group	10:15 a.m. - 11:15 a.m.	Elizabeth H
Cy Pres Working Group	10:15 a.m. - 11:15 a.m.	Madeline CD
FIscal Policy Reform Working Group	10:15 a.m. - 11:15 a.m.	Elizabeth G
Opening Luncheon, *sponsored by AT&T* *Speaker: Randall Stephenson, Chairman, CEO, and President, AT&T Keynote: Gov. Rick Perry (TX)*	11:30 a.m. - 1:30 p.m.	Douglas ABC
Workshop: *Transferring Credits: Easing the Burden of Students and Taxpayers*	1:45 p.m. - 3:00 p.m.	Elizabeth F
Workshop: *Regional Climate Initiatives*	1:45 p.m. - 3:00 p.m.	Elizabeth G
Workshop: *Panel on Prescription Drug Abuse: Good Medicines, Bad Behavior*	1:45 p.m. - 3:00 p.m.	Elizabeth H
Workshop: Visa	3:15 p.m. - 4:30 p.m.	Elizabeth F
Workshop: *Show Me the Money: Improving Budget Transparency in the States*	3:15 p.m. - 4:30 p.m.	Elizabeth G
Workshop: *Restoring Good Faith to Insurance "Bad Faith" Legislation*	3:15 p.m. - 4:30 p.m.	Elizabeth H
Diageo Wine and Cheese Reception *Open to all attendees*	5:00 p.m. - 6:00 p.m.	Elizabeth ABCDE
Chairman's Reception, *by invitation only Sponsored by AT&T*	5:30 p.m. - 6:30 p.m.	Ford ABC
International Relations Reception *Sponsored by Reynolds American*	6:00 p.m. - 7:00 p.m.	Elizabeth Terrace
California Welcome Reception aboard the *U.S.S. Midway, sponsored by California Host Committee*	6:30 p.m. - 8:30 p.m.	*U.S.S. Midway*
Hospitality Suite	9:00 p.m. - 11:00 p.m.	Ford ABC

Friday, August 6, 2010

Registration Open	7:30 a.m. - 5:00 p.m.	Litrenta Foyer

Agenda

Plenary Breakfast, *sponsored by Bayer Corporation* *Speaker: Greg Babe, President and CEO, Bayer Corporation* *Keynote: Gov. Joe Manchin (WV), invited*	8:00 a.m. - 9:15 a.m.	Douglas ABC
ALEC Exhibition Hall Open	9:30 a.m. - 5:00 p.m.	Elizabeth ABCDE
Workshop: *Cutting Crime and Budgets: Proven Solutions for Your State*	9:30 a.m. - 10:45 a.m.	Elizabeth F
Workshop: *The Changing Face of Journalism in the States*	9:30 a.m. - 10:45 a.m.	Elizabeth G
Workshop: *Creating True and Lasting Budget Reform in Your State*	9:30 a.m. - 10:45 a.m.	Elizabeth H
Task Force Chairs Meeting	11:00 a.m. - 12:15 p.m.	Mohsen AB
Workshop: *The 10th Amendment: Federalism and Restoring State Sovereignty*	11:00 a.m. - 12:15 p.m.	Elizabeth F
Workshop: *Building a Free-Market Movement in Your State*	11:00 a.m. - 12:15 p.m.	Elizabeth G
Workshop: *Protecting Philanthropic Freedom*	11:00 a.m. - 12:15 p.m.	Elizabeth H
Plenary Luncheon, *sponsored by Allergan* *Speaker: Lynn Salo, Vice President, Allergan Medical US Breast Aesthetics Division* *Keynote:*	12:30 p.m. - 2:15 p.m.	Douglas ABC
Task Force: Commerce, Insurance, and Economic Development	2:30 p.m. - 5:30 p.m.	Elizabeth G
Task Force: Civil Justice	2:30 p.m. - 5:30 p.m.	Manchester DE
Task Force: Education	2:30 p.m. - 5:30 p.m.	Manchester GH
Task Force: Telecom and IT	2:30 p.m. - 5:30 p.m.	Manchester AB
Education Task Force Reception, *by invitation only* *Sponsored by Bridgepoint Education*	5:30 p.m. - 6:30 p.m.	Manchester Foyer
Incoming Chairman's Reception, *by invitation only* *Sponsored by Reynolds American*	5:30 p.m. - 6:30 p.m.	Ford ABC
State Delegation Night	6:00 p.m.	Ford ABC
Hospitality Suite	9:00 p.m. - 11:00 p.m.	



Agenda

Saturday, August 7, 2010

Registration Open	7:30 a.m. - 12:00 p.m.	Litrenta Foyer
ALEC Exhibition Hall Open	9:30 a.m. - 12:00 p.m.	Elizabeth ABCD
Plenary Breakfast, *Sponsored by Pfizer*	8:00 a.m. - 9:15 a.m.	Douglas ABC
Task Force: Public Safety and Elections	9:30 a.m. - 12:30 p.m.	Elizabeth H
Task Force: Health and Human Services	9:30 a.m. - 12:30 p.m.	Manchester AB
Task Force: Energy, Environment, and Agriculture	9:30 a.m. - 12:30 p.m.	Manchester GH
Task Force: Tax and Fiscal Policy	9:30 a.m. - 12:30 p.m.	Elizabeth G
Plenary Luncheon, *sponsored by Visa* *Speaker: Frm. Maj. Leader Dick Armey*	12:30 p.m. - 2:15 p.m.	Douglas ABC
Closing Ceremonies	4:00 p.m. - 5:00 p.m.	

Sunday, August 8, 2010

Prayer Service *Speaker: Cal Thomas, Syndicated Columnist*	9:00 a.m. - 10:30 a.m.	Ford ABC

Health and Human Services Task Force Meeting
ALEC's 37th Annual Meeting
Saturday, August 7, 2010
9:30 a.m. – 12:30 p.m.

TENTATIVE AGENDA

9:30 a.m. **Welcoming Remarks**
Introduction of HHS Task Force Executive Committee
Recognition of New and Returning ALEC Private Sector Members
Approval of Minutes from ALEC's 2010 Spring Task Force Summit
Iowa Representative Linda Upmeyer, Public Sector Chair
Julie Corcoran, Bayer Healthcare, Private Sector Chair

Update on ALEC's Health Reform Initiative
Recognition of ALEC HHS Members Who Introduced ALEC HHS Models in 2010
Christie Herrera, Task Force Director

9:45 a.m. **SPECIAL PRESENTATIONS**
Moderated by Iowa Representative Linda Upmeyer, Public Sector Chair

Virginia's Success with ALEC's *Freedom of Choice in Health Care Act*
Joe Guarino, Alliance of Health Care Sharing Ministries

10:00 a.m. **ALEC's *Taking the Best* and the Federal Health Reform Debate**
Sal Bianco, The Doctors Company

10:15 a.m. **MODEL LEGISLATION: DISCUSSION AND VOTING**
Moderated by Julie Corcoran, Bayer Healthcare, Private Sector Chair

Resolution on Point-of-Service Reimbursement
Sponsored by Libby Brunsvold, MedImmune

10:45 a.m. ***Patients First Medicaid Reform Act***
Sponsored by Joe Coletti, John Locke Foundation

11:15 a.m. **SPECIAL PRESENTATIONS**
Moderated by Julie Corcoran, Bayer Healthcare, Private Sector Chair

The Evolution of Third-Party Payment in Health Care
Byron Schlomach, Goldwater Institute

11:30 a.m. **[Topic TBD]**
Jeff Buel, Johnson & Johnson

11:40 a.m. **MODEL LEGISLATION: DISCUSSION AND VOTING**
Moderated by Iowa Representative Linda Upmeyer, Public Sector Chair

Medication Therapy Management Services Act
Sponsored by Gaspar Laca, GlaxoSmithKline, and North Carolina Representative Jeff Barnhart

12:10 p.m. ***Resolution on Improving Quality and Lowering Costs for States Through Medicaid Managed Care***
Sponsored by Georgia Senator Renee Unterman

12:30 p.m. **Good of the Order/Adjournment**

RESOLUTION ON POINT-OF-SERVICE REIMBURSEMENT (DRAFT, AUGUST 7, 2010)

SUMMARY

This resolution encourages school-based influenza vaccine programs and urges the State Insurance Commissioner and the State Department of Health to convene a stakeholder meeting regarding private insurance coverage of school-based influenza vaccination programs.

RESOLUTION

WHEREAS, Every year in the United States, on average, more than 200,000 people are hospitalized from influenza-related complications and about 36,000 people, mostly in the elderly, die from influenza-related causes; and

WHEREAS, The most effective strategy for preventing influenza is annual vaccination; and

WHEREAS, School-aged children ages five to 19 years have the highest rates of influenza infection, and school-aged children are the major vectors for influenza transmission that spread the virus to adults and the elderly in the community, causing substantial socioeconomic impact; and

WHEREAS, The U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices recommends universal vaccination for influenza; and

WHEREAS, Influenza vaccination rates for school-aged children are extremely low, ranging from 21.1% (high-risk) to 33% (healthy) during the 2006-07 influenza season, and new immunization strategies are needed to improve vaccination in this population; and

WHEREAS, The potential threat of an influenza pandemic underscores the importance of building a school-based vaccination infrastructure as federal pandemic preparedness plans call for the vaccination of an unprecedented number of children with the pandemic vaccine, potentially in the school setting; and

WHEREAS, School-based influenza vaccination programs have grown substantially in recent years and have been particularly successful in schools in which a majority of children qualify for the vaccine though the federal Vaccines for Children program; and

WHEREAS, A barrier in school-based influenza vaccination programs is the reimbursement of the vaccine's cost to children who have private insurance that covers the influenza vaccine but does not recognize the school setting as a "point of service" for administration of the vaccine; and

WHEREAS, Private insurance's recognition of alternative delivery venues, such as schools, for the administration of the influenza vaccine would increase access for all school-aged children to receive vaccination to protect themselves and their communities from influenza.

NOW THEREFORE BE IT RESOLVED that school-based influenza vaccination programs should be encouraged to help increase school-aged children's access to immunization, help protect them from influenza-related illness and reduce school absenteeism due to influenza, and help provide protection to the community at large.

BE IT FURTHER RESOLVED that the **{insert state legislature}** strongly urges the **{insert state insurance commissioner}** and **{insert state department of health}** to convene a meeting with private insurers, the public health community, and vaccine stakeholders to discuss ways to encourage private insurers who already cover influenza vaccination to cover all reasonable and customary expenses, including the cost of the vaccine and administration fee, incurred when the influenza vaccine is administered outside of the physician's office in a school or other related settings.

PATIENTS FIRST MEDICAID REFORM ACT
(DRAFT, AUGUST 7, 2010)

SUMMARY

The purpose of this act is to consolidate and update ALEC's *Access to Medicaid Act*, which offered vouchers for private insurance coverage, and ALEC's *Market Based Medicaid Reform Act*, which established consumer-directed medical accounts. This legislation would put patients in charge of their care and provide them incentives to control their medical dollars. Although not spelled out in the legislation itself, as with all waivers and model legislation, it can be a narrowly targeted pilot program or a full-scale effort to reform the state's entire Medicaid system, as in Rhode Island.

MODEL LEGISLATION

Section 1. Title. This Act may be cited as the *Patients First Medicaid Reform Act*.

Section 2. Definitions.

A. "Medicaid Savings Account," or "MSA," is an account funded by the **{insert state Medicaid agency}** which can be used for medical expenses and qualifying non-medical expenses as approved by the **{insert state Medicaid agency}**.

Section 3. Federal Waiver. The **{insert state Medicaid agency}** shall seek a Medicaid waiver from the Centers for Medicare and Medicaid Services to receive **{insert percentage}** of federal funding as a five-year block grant.

Section 4. Qualifying Policies.

A. To qualify, a health insurance policy must meet federal requirements for Health Savings Account (HSA) eligibility.

B. Policies must cover federally mandated Medicaid benefits.

C. Policies will be exempt from other state mandated benefits.

D. HSA-eligible policies available through the state or federal high-risk pool are eligible for those individuals who meet enrollment criteria.

Section 5. Establishment of Benefits.

A. The **{insert state Medicaid agency}** shall establish Medical Savings Accounts for Medicaid enrollees or their families with the **{insert state treasurer}** *(Drafting Note: Accounts may also be established with the state employee retirement system, or with private vendors)*.[i]

B. The amount deposited in an individual's account shall be equal to the amount required to purchase a qualifying individual or family high-deductible policy and fund a portion of a related HSA.

1. This amount shall be adjusted for age and health status.

2. Funds shall be made available on a pro-rated basis each month.

C. Only high-deductible policies that meet federal requirements to be eligible for an HSA shall be eligible for purchase.

Section 6. Continuation of Benefits.
A. A current Medicaid recipient or guardian who becomes employed may continue to receive premium supports and MSA deposits as long as the recipient continues to qualify and keeps the same policy. Subsidies will phase out with income until the recipient no longer qualifies for Medicaid.

B. The employer of a current Medicaid recipient or guardian who enrolls in an employer-sponsored insurance policy shall receive premium support payments from the **{insert state Medicaid agency}**. Payments will phase out with income until the recipient no longer qualifies for Medicaid.

C. A current recipient or guardian shall have the option to continue the same health insurance coverage, without subsidies.

D. **{Insert percentage}** of any unspent funds in an MSA account, including earnings, shall vest to a Medicaid recipient or guardian who no longer qualifies for Medicaid.

Section 7. Other Uses of Funds for Individuals.
A. A Medicaid recipient may apply in writing to the **{insert state Medicaid agency}** to use MSA funds in excess of any insurance out-of-pocket maximum for education, job training, child care, or other qualifying non-medical expenses.

B. The **{insert state Medicaid agency}** shall respond within seven days to each such request and have a final decision within 30 days.

Section 8. Transparency and Accountability.
A. All transactions involving the state shall be considered public information and posted in an online database after redaction of personal identifying information.

B. The **{insert state Medicaid agency}** shall provide an annual report on cost savings, use of preventive care services, enrollee transition from Medicaid, and other appropriate information.

Section 9. {Severability Clause}
Section 10. {Repealer Clause}
Section 11. {Effective Date}

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[i] *(Drafting Footnote: If handled through private vendors, it may be worth adding a clause like: "No single vendor shall manage more than [X%] of accounts by value.")*

MEDICATION THERAPY MANAGEMENT SERVICES ACT
(DRAFT, AUGUST 7, 2010)

SUMMARY

This model legislation establishes medication therapy management services for medical assistance patients provided by appropriately trained pharmacists working within a coordinated care delivery system such as a patient-centered medical home or accountable care organization. This is meant to accompany state-based medical home program authorization legislation and already-established, state-based medical home programs.

The redefined role of primary care embodied in the patient-centered medical home presents a unique opportunity to maximize both the quality and coordination of patient care. Complex chronic diseases and their associated co-morbidities can be addressed in a more collaborative and clinically effective way for patients. A significant factor in the management of all chronic diseases is the use of medications. Consequently, producing more positive clinical outcomes within the patient-centered medical home will often require the provision of comprehensive and effective medication management by an inter-professional medical home team.

Community Care of North Carolina (CCNC) is a well-known example of a Medicaid medical home program that incorporates comprehensive medication management by clinical pharmacists into a multidisciplinary team to provide patient-centered comprehensive and coordinated care. CCNC's approach has been shown to improve quality of care and control costs.

MODEL LEGISLATION

Section 1. Title. This Act may be cited as the *Medication Therapy Management Services Act*.

Section 2. Definitions and Clarifications.

A. "Medication therapy management services" means the provision of the following pharmaceutical care services by a licensed pharmacist in order to optimize appropriate medication use to achieve clinical goals of therapy:

1. Performing or obtaining necessary assessments of the patient's health status;

2. Formulating a medication treatment plan;

3. Monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

4. Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

5. Documenting the care delivered and communicating essential information to the patient's other primary care providers;

6. Providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

7. Providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

8. Coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient in coordinated care delivery systems such as the patient-centered medical home and accountable care organizations.

B. Nothing in this Act shall be construed to expand or modify the scope of practice of the pharmacist as defined in the **{insert state Pharmacy Act}**.

Section 3. Medication Therapy Management Services.
A. Medical assistance may cover medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by **{insert state Medicaid agency}** that has resulted or is likely to result in significant nondrug program costs, or as requested by the physician or other licensed prescriber.

Section 4. Reimbursement for Participating Pharmacists.
A. To be eligible for reimbursement for services under this Act, a pharmacist must meet the following requirements:

1. Have a valid license in the state;

2. Have graduated from an accredited college of pharmacy or completed a structured and comprehensive education program approved by the **{insert state board of pharmacy}** and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

3. Be practicing in an ambulatory care setting as part of a multidisciplinary team, or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in a home setting, or telephonically in direct communication between the pharmacist and patient, so long as the quality of the interaction, clinical results, and economic results are documented to be equivalent to face to face interactions if the service is ordered by the provider-directed care coordination team; and

4. Make use of an electronic patient record system that meets state standards.

B. For purposes of reimbursement for medication therapy management services, the **{insert state Medicaid agency}** may enroll individual pharmacists as medical assistance providers.

C. The **{insert state Medicaid agency}** also may establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

D. For purposes of this section, "home setting" shall not include long-term care or group homes.

Section 5. Medication Therapy Management Advisory Committee.
A. The **{insert state Medicaid agency}**, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups, shall convene an 11-member Medication Therapy Management Advisory Committee to advise the **{insert state Medicaid agency}** on the implementation and administration of medication therapy management services.

B. The committee shall be comprised of:

1. Two licensed physicians;

2. Two licensed pharmacists;

3. Two consumer representatives;

4. Two health plan company representatives; and

5. Three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists.

C. The **{insert state Medicaid agency}** shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance and general assistance medical care programs that can be attributable to this coverage, including the effect on emergency room and hospital costs. The evaluation shall be submitted to the legislature by **{insert date}**. The **{insert state Medicaid agency}** may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation**.**

Section 6. {Severability Clause}
Section 7. {Repealer Clause}
Section 8. {Effective Date}

COMMUNITY CARE OF NORTH CAROLINA

ACCESS II & III

Community Care At a Glance

Leadership Works • Partnership Works • Innovation Works ◄

Overview

Under the Community Care program (formerly known as Access), North Carolina is building community health networks that are organized and operated by community physicians, hospitals, health departments and departments of social services.

By establishing provider networks, the program is putting in place the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.

Fourteen networks with more than 1,380 practices across North Carolina are working with their local health departments, hospitals, and social service agencies to better manage the care of 970,558 Medicaid & NCHC Enrollees.

Approach

How does the Community Care approach differ from other efforts? Community Care of North Carolina:

- Works directly with those community providers who have traditionally cared for North Carolina's low-income residents.
- Builds private and public partnerships where community providers can work together to cooperatively plan for meeting patient needs and where existing resources can be used most efficiently.
- Conveys responsibility for managing the care of a specific Medicaid population to a community network.
- Places responsibility for performance (and improvement) in the hands of those who actually deliver the care.
- Ensures that all funds are kept local and go to providing care.
- Puts in place the local networks that can manage all Medicaid patients and Medicaid services, and can address larger community health issues.

Savings

A recent actuarial study from Mercer Human Resource Consulting Group found, when comparing what the access model would have cost in SFY07, without any concerted efforts to control costs, the program saved approximately $147 million.

Network

Access Care (150 provider sites including UNC)

Access II Care of Western NC (Buncombe, Henderson, Madison, Mitchell, McDowell, Polk, Transylvania and Yancey)

Access III of Lower Cape Fear (Bladen, Brunswick, Columbus, New Hanover, Onslow and Pender)

Carolina Collaborative Community Care (Cumberland)

Carolina Community Health Partnership (Cleveland and Rutherford)

Northwest Community Care (Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin)

Community Care Partners of Greater Mecklenburg (Anson, Mecklenburg, Union)

Community Care of Wake and Johnston Counties (Wake, Johnston)

Community Care Plan of Eastern Carolina (Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington and Wilson)

Community Health Partners (Gaston and Lincoln)

Northern Piedmont Community Care (Durham, Franklin, Granville, Person, Vance and Warren)

Partnership for Health Management (Guilford, Randolph and Rockingham)

Sandhills Community Care Network (Harnett, Hoke, Lee, Montgomery, Moore, Richmond and Scotland)

Southern Piedmont Community Care Plan (Cabarrus, Rowan and Stanly)

Community Care Networks

- Non-Profit Organization Comprised of Safety Net Providers
- Steering and Medical Management Committees
- Receive $3.00 PMPM from the State
- Manage Care of Medicaid Enrollees
- Hire Case Managers/Medical Management Staff

Key Elements

Community networks are putting into place the management tools that programs need to achieve improved performance:

- Implementing Best Practices
- Implementing Disease Management
- Managing High-Risk Patients
- Managing High-Cost Services
- Building Accountability

Clinical Improvement Initiatives

Physician leaders from participating networks come together to design and develop clinical improvement initiatives:

- Asthma Disease Management
- Congestive Heart Failure Disease Management
- Diabetes Disease Management
- Emergency Room Initiatives
- Pharmacy Management Initiatives
- Case Management of High Risk / High Cost Patients

Pilot Initiatives

- Aged, Blind, Disabled/Chronic Care
- Health Choice
- COPD
- Special Needs Children

Performance and Results

Asthma Disease Management
2000-2005

- All practices adopted best practice guidelines from National Institute Health with expansion to 700 additional practices from 2002-2004.
- 28% increase in flu vaccines
- Over 90% of staged asthma patients on appropriate preventive medication.
- The Sheps Center Report estimated the asthma disease management program saved $3.5 million from 2000-2002 from lower inpatient admissions and emergency department visits.

Diabetes Disease Management
2000-2004

- 10% increase in referrals for eye exams.
- 62% increase in flu vaccines.
- Continued Care visits are at 94%. Improved 7% since baseline.
- BP at every cc visit at 96%. Improved 8% since baseline.
- Foot exams are at 71%. Improved 18% since baseline.
- Lipid testing is at 77%. Improved 11% from 2004-2005.
- All practices adopted best practice guidelines from American Diabetes Association.
- The Sheps Center Report estimated the diabetes disease management program saved $2.1 million from 2000-2002.

Emergency Department Initiative *2001 – 2002*

- Care management follow-up, outreach and education on all enrollees with 3 or more visits to the ED in a six month period of time
- 30% lower per member per month cost
- 13% lower ED rate

Pharmacy Management Initiatives

Prescription Advantage List (PAL)

- 22% lower expenditures in PAL Pilot ($640,000 actual savings from February – March 2003)
- Rolled out statewide November 2003
- In 2004, cost savings from over-the-counter (OTC) prescribing estimated at $1.7 million

Nursing Home Polypharmacy

- Patients Reviewed – 9,208
- Recommendations Made – 8,559 (74% implemented)
- Physician / pharmacist team review drug regime and make recommendations to change prescriptions
- $6 million in cumulative savings since November 2002 (savings of $9 million estimated for 2004)

Case Management of High Cost/ High Risk

- Care management follow-up, outreach and education on recipients with $25,000 or more in Medicaid expenditures in six months period of time.
- Defining process to use DxCG predictive modeling to target individuals at greatest risk based on historical utilization and diagnoses.

The Opportunity for Comprehensive Medication Management Within the Patient-Centered Medical Home Structure

The redefined role of primary care embodied in the Patient Centered Medical Home (PCMH) presents a unique opportunity to maximize both the quality and coordination of patient care. Complex chronic diseases and their associated co-morbidities can be addressed in a more collaborative and clinically effective way for patients.

A significant factor in the management of all chronic diseases is the use of medications. Consequently, producing more positive clinical outcomes within the PCMH will often require the provision of comprehensive and effective medication management **by an interprofessional medical home team**.

"We found that over half of our patients in the "resistant hypertension" clinic were actually not taking their medications."

Bruce McCarthy, M.D. - Medical Director, Primary Care

Allina Health System - Minnesota

This paper presents the rationale for developing a PCPCC guideline document addressing medication management in the medical home, by outlining opportunities to positively impact the care of patients.

Four out of five patients who visit a physician leave with at least one prescription[1], and nearly one-third of all American adults take five or more different medications. Medications are involved in 80% of all treatments and are the most common modality for controlling and/or preventing the progression of chronic disease.

Medicare beneficiaries with multiple chronic illnesses:

- see an average of 13 different physicians and have 50 different prescriptions filled each year;
- account for 76% of all hospital admissions;
- account for 88% of all prescriptions filled;
- account for 72% of physician visits, and
- are 100 times more likely to have a preventable hospitalization than someone with no chronic conditions.[2]

[1] *The chain pharmacy industry profile*. National Association of Chain Drug Stores. 2001

[2] Testimony of Gerard F. Anderson, Ph.D., Johns Hopkins Bloomberg School of Public Health, Health Policy and Management, before the Senate Special Committee on Aging, "The Future of Medicare: Recognizing the Need for Chronic Care Coordination, Serial No. 110-7, pp. 19-20 (May 9, 2007)

While only 10% of total healthcare costs are attributable to medications, their ability to control disease and impact overall cost, morbidity, and productivity- when appropriately utilized- is enormous.[3]

The need for and value of a more comprehensive and systematic approach to the management of medications is increasingly clear. Patients need and deserve appropriate, effective, safe and convenient medications. The PCMH, because of its unique focus on quality outcomes and coordination of care, is the logical approach to provide a systematic medication management process that fully utilizes the knowledge and skills of the physician together with those of other team members -- especially pharmacists who can collaboratively deliver care and services that help patients safely and more effectively use their medications. In short, comprehensive medication management can, and should, be an essential service of the effective PCMH.

Actively engaging patients to understand their personal medication experience - including behaviors and beliefs related to how they actually take the medications, is an essential beginning to maximizing positive clinical outcomes. Individualized medication care plans that are designed to achieve the clinical goals of therapy and that meet patients' specific needs are essential. Regularly updating the clinical goals of medication use as patients' conditions and responses to various therapies change is also crucial to the achievement of quality outcomes. Follow-up of actual patient outcomes allows us to learn how medications work in the presence of multiple co-morbidities and multiple medications.

"When we looked at our patients with asthma that were seen in the ER or hospital, we found that over half were not on a controller medication. Now all CCNC networks have a Pharm.D. to assist with medication management of high cost patients. The result- we were able to increase controller medication use in these asthmatic patients to 93% - lowered hospital admission rates by 34%, ER rates by 8%, and lowered total cost by episode for children enrolled in CCNC by 24%."

L. Allen Dobson Jr. M.D., FAAFP, Former Assistant Secretary
North Carolina Department of Health & Human Services

As the number of clinicians involved with a patient's care increases, the potential for drug therapy problems increases and the patient's understanding of the role of their medications can become more confusing. The PCMH has a unique opportunity to effectively manage medications for and with its patients.

"I have been taking this medication for almost seven years. I have never been clear on why I am taking it or what it is supposed to do for me, and, I have never had anyone who had the time to explain it to me. Now I can ask questions and discuss my concerns about my medications."

J.P. (Patient receiving medication management services

at a medicine clinic in Minneapolis, MN)

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[3] Source: Centers for Medicare & Medicaid Services, "National Health Expenditures," 7 January 2008, http://www.cms.hhs.gov/NationalHealthExpendData.

Systematic approaches to medication management must be considered during transitions of care such as post-hospital discharge. Most physicians and providers have the training and experience to manage medications effectively within their area of general or specialist knowledge, but may seek additional consultation in managing medications outside of their usual scope of care or when patients are not reaching clinical goals of therapy. Currently, primary care providers frequently refer patients back to a medical specialist for medication adjustments, even when the diagnosis is well established. Common examples include referral to a pulmonologist for worsening asthma or COPD, to a cardiologist for poorly controlled hypertension, or to a psychiatrist for worsening psychosis. A primary care clinician in the PCMH team that has a specially trained pharmacist (either integrated in the team internally, or as an external referral resource) would be a more logical and cost effective choice for medication change and management recommendations.

Many believe that an EMR linked to e-prescribing will allow for better medication reconciliation and management. However reliance on e-prescribing and EMR/claims will only capture about half of medications actually consumed by patients. Missing from these data sources are prescription samples, medications bought out-of-pocket (i.e., large chain $4 prescriptions not documented in claims systems), medications previously prescribed (back of the medicine cabinet) nonprescription medications, "alternative" medications, those obtained from family and friends, and internet purchases.

Most importantly, medication management services can produce significantly improved clinical outcomes. A report measuring the impact of medication therapy management services being delivered to Minnesota Medicaid recipients indicates that 77% of patients with diabetes who received this service achieved the QCare 2006 A1C benchmark. In addition 36% of patients with diabetes met all the performance-based benchmark standards compared to a state average of 6%. (Isetts, BI. Final Report: Evaluating Effectiveness of the Minnesota Medicaid Therapy Management Care Program, December 14, 2007.) This service has been shown to make a clinically significant difference in patients' lives.

For health plans and payers, these services have resulted in returns on investment between 4:1 and 12:1 by avoiding unnecessary ED visits, hospitalizations, and specialist/other visits, while appropriate use of medications is maximized. (Isetts BI, Schondelmeyer SW, Artz MB, et al. Clinical and economic outcomes of medication therapy management services: The Minnesota Experience, JAmPharmAssoc. 2008;48:203-211.) Both health outcomes and clinical outcome measures improved, enhancing clinician achievement of quality performance indicators.

"Most patient care interactions involve medications and the limitations both in knowledge and time on my part make the addition of a clinical pharmacist on the medical home team MANDATORY ! I would have a difficult time maintaining our current standards without this person on board."

James Bergman, M.D. – Staff Physician, Group Health Permanente

Associate Professor, Family Medicine, University of Washington, Seattle

The rationale for developing a PCPCC guideline document addressing medication management is to clearly outline, for evolving PCMH's, (1) the value, role, responsibility, and opportunities related to effective medication management, which is integrally linked to enhanced clinical outcomes, infrastructure planning (such as HIT), and (2) examples of payment approaches that have been utilized for these services.

We recognize that the expanded team for a highly functional PCMH includes other providers as an extension of the "medical home" (such as behavioral health experts, physical therapists, and nutritionists), and we believe this includes and should recognize the professional role and contribution that pharmacists can make in helping both providers and patients address ever more complex medication therapy issues, as has been demonstrated in Community Care of North Carolina, Fairview Health Systems, The Mayo Clinic in Minnesota, Group Health Permanente, and others (see attached appendices for several practice profiles).

The recognition of the need for this service and the demonstrated effectiveness of the service when provided in a collaborative and interprofessional framework, lead us to conclude that a systematic approach to medication management can and should be a hallmark component of the effective PCMH.

> ***"Pharmaceuticals are the most common medical intervention, and their potential for both help and harm is enormous. Ensuring that the American people get the most benefit from advances in pharmacology is a critical component of improving the national health care system."***
>
> ***Institute of Medicine***[4]

PCPCC Medication Management Task Force Leadership Team

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[4] Institute of Medicine - National Academy of Sciences- Informing the Future: Critical Issues in Health, Fourth Edition pg. 13 http://www.nap.edu/catalog/12014.html

Medication Management Services (MMS) and the Patient-Centered Medical Home:

Practice Profile

Type of Practice/Facility:	**Multi-specialty physician private group practice**
Location:	**Greensboro, North Carolina**
Pharmacist Relationship To Practice:	**Physically present, contracted staff (medical practice contract with clinical pharmacy services private practice), practicing under collaborative drug therapy management protocols and "clinical pharmacist practitioner" licensing (NC specific).**
MMS provision:	**Patient-specific care related to:** • **ID/document medication-related problems** • **Anticoagulation management and testing** • **Insulin/oral hypoglycemic therapy** • **Hyperlipidemia therapy** • **Multi-disease medication regimen optimization** • **Patient education** • **Longitudinal outcomes monitoring**
Access to MM Service:	**(1) Physician/PCP referral** **(2) Direct patient request/appointment** **(3) Benefit design/contract**
Payment/Billing Methods: (patient/coverage determined)	**(1) Incident-to-physician using E&M CPT codes** **(2) MTM CPT codes for Medicare patients** **(3) Patient-pay**
Service Assessment Measures (documented):	**(1) Clinical treatment goal achievement** **(2) Patient adherence** **(3) Adverse effects identified/prevented**

Medication Management Services (MMS) and the Patient-Centered Medical Home:

Practice Profile

Type of Practice/Facility:	**Community pharmacy practice; pharmacists with focused training in medication management, working with small physician groups in rural Minnesota**
Location:	**Minnesota – several small to medium communities: Willmar, Little Falls, St. Cloud, Princeton**
Pharmacist Relationship To Practice:	**Pharmacist is employed by the pharmacy chain; medication management practice is separately structured from the dispensing operation**
MMS provision:	**Patient-specific care related to:** • **Comprehensive assessment of medication and medical conditions** • **Identification/documentation of drug therapy problems** • **Physician-pharmacist care plan development** • **Follow up/evaluation visits** • **Written documentation of encounters to physician and patient**
Access to MM Service:	**(1) Physician/PCP referral to pharmacist** **(2) Direct patient request/appointments** **(3) Employers/other payer referral**
Payment/Billing Methods:	**(1) MTM CPT code billing/documentation** **Minnesota Medicaid** **Self-insured employers (U. of Minn., General Mills, Fairview Health System, state employees)** **(2) Patient self-pay/copayments**
Service Assessment Measures (documented):	**(1) Volume and complexity of patients** **(2) Clinical goals achievement** **(3) Hospitalizations avoided/clinic visits prevented** **(4) Medication cost savings** **(5) Days at work saved** **(6) Patient adherence to regimen**

Medication Management Services (MMS) and the Patient-Centered Medical Home:

Practice Profile

Type of Practice/Facility:	**Group model health maintenance organization providing ambulatory care and acute care services for enrolled members**
Location:	**Denver, Colorado**
Pharmacist Relationship To Practice:	**Both physically and virtually present models, employee staff, practicing under approved collaborative drug therapy management protocols; integrated within specific primary care clinics, medical services, and departments**
MMS provision:	**Patient-specific care related to:** • **Identify/document medication-related problems** • **CVD/hypertension therapy** • **Anticoagulation management** • **Chronic care/geriatrics/palliative care** • **Mental health/neurology** • **Care transition/medication reconciliation** • **Patient education (in-person/telephonic)**
Access to MM Service:	**(1) Physician/PCP referral** **(2) Inter-service referrals** **(3) Pharmacist follow up appointments** **(4) Direct patient request/appointments**
Payment/Billing Methods:	**(1) PM/PM Capitation Model** **(2) Patient-pay/co-pay**
Service Assessment Measures (documented):	**(1) Clinical treatment goals achievement** **(2) NCQA/HEDIS measures (various)** **(3) Annualized cost avoidance/ROI** **(4) Patient satisfaction**
Physician/Staff View:	**"My primary care clinical pharmacy specialist is as important as my nurse and LPN in getting work done efficiently throughout the day and in giving excellent care to our patients. I can't imagine working without her help."**
Patient/Caregiver View:	**"I call them my heart team …I pay attention to what they tell me," [The patient] looks forward to calls from her pharmacist, who adjusts her medications for cholesterol, thyroid disease and blood pressure. "He makes sure my heart is protected, let me tell ya,"** **– Patient interview – Denver Post – March 28, 2009.**

Medication Management Services (MMS) and the Patient-Centered Medical Home:

Practice Profile

Type of Practice/Facility:	**Physician-directed interprofessional community health center (HRSA supported)**
Location:	**Tucson, Arizona**
Pharmacist Relationship To Practice:	**Physically present, employee staff, practicing under collaborative drug therapy management protocols**
MMS provision:	**Patient-specific care related to:** • **ID/document medication-related problems** • **Insulin/oral hypoglycemic therapy** • **Hyperlipidemia therapy** • **CVD/hypertension therapy** • **Patient education**
Access to MM Service:	**(1) Physician/PCP referral** **(2) Pharmacist follow up appointments** **(2) Direct patient request/appointments**
Payment/Billing Methods:	**(1) HRSA/community funded** **(1) MTM CPT codes (documentation only)** **(2) Patient-pay/co-pay**
Service Assessment Measures (documented):	**(1) Clinical treatment goals achievement** **(2) Patient adherence** **(3) Adverse effects identified/prevented**

Physician/Staff View: **"Working with a pharmacist as part of my medical service team is like having an additional clinical resource in my pocket. I have access to a wealth of medication knowledge to improve patient safety and health outcomes. The collegiality found with a pharmacist who can build trust with me and our patients [allows] us to complement each other's services and to meet mutual goals with our patients." – Arthur Martinez, M.D. – Chief Medical Officer**

Medication Management Services (MMS) and the Patient-Centered Medical Home:

Practice Profile

Type of Practice/Facility:	**University-based interprofessional primary care practice, serving university employees/dependents (self-insured); clinical education site for physicians, pharmacists, nurses.**
Location:	**Columbus, Ohio**
Pharmacist Relationship To Practice:	**Physically present, employee staff, practicing under approved collaborative drug therapy management protocols; three part-time primary care physicians, nurse practitioner, practice manager**
MMS provision:	**Patient-specific care related to:** • **Identify/document medication-related problems** • **Medication goals/plan development** • **Disease/medication management coordination** • **Medication access assistance** • **Patient education (in-person/telephonic)**
Access to MM Service:	**(1) Physician/PCP referral** **(2) Pharmacist follow up appointments** **(3) Direct patient request/appointments**
Payment/Billing Methods:	**(1) Self-insured university employee health benefit** **(2) Patient co/pay**
Service Assessment Measures (documented):	**(1) Clinical treatment goals/care plan achievement** **(2) NCQA/HEDIS measures** **(3) Annualized cost avoidance of higher intensity services** **(4) Patient satisfaction**
Physician/Staff View:	**"Practicing medicine as a part of an interprofessional team has greatly enhanced the quality of patient care I am able to deliver. I have noted a marked increase in patient adherence and improved outcomes as a result of the more intensive education and medication monitoring that we are able to provide."** **– Kelly Hall, M.D., Primary Care Physician**

Medication Management Services (MMS) and the Patient-Centered Medical Home:

Practice Profile

Type of Practice/Facility:	**Staff model health maintenance organization/medical home framework providing acute and chronic ambulatory care services to enrolled members.**
Location:	**Seattle, Washington**
Pharmacist Relationship To Practice:	**Physically present, salaried employee staff, practicing under approved collaborative drug therapy management protocols; integrated as core team members within primary care clinics.**
MMS provision:	**Patient-specific care related to:** • **Identify/document medication-related problems** • **CVD/hypertension therapy** • **Anticoagulation management** • **Group care registries for chronic disease panels** • **Patient education (in-person/telephonic)**
Access to MM Service:	**(1) Physician/PCP referral** **(2) Pharmacist-initiated follow up appointments** **(3) Direct patient request/appointments**
Payment/Billing Methods:	**(1) PM/PM Capitation Model** **(2) Patient-pay/co-pay**
Service Assessment Measures (documented):	**(1) Clinical treatment goals achievement** **(2) HEDIS/NCQA measures** **(3) Annualized cost avoidance/ROI** **(4) Patient satisfaction** **(5) Medication/treatment adherence**
Physician/Staff View:	**"Most patient care interactions involve medications and the limitations both in knowledge and time on my part make the addition of a clinical pharmacist on the medical home team MANDATORY ! I would have a difficult time maintaining our current standards without this person on board."-** **James Bergman, M.D. – Staff Physician, Associate Professor of Family Medicine, U. of Washington**

RESOLUTION ON IMPROVING QUALITY AND LOWERING COSTS FOR STATES THROUGH MEDICAID MANAGED CARE (DRAFT, AUGUST 7, 2010)

SUMMARY

This resolution encourages the implementation of coordinated, risk-based, capitated programs to control costs and improve quality of care for all Medicaid beneficiaries, including those requiring long-term care services.

RESOLUTION

WHEREAS, Medicaid is an entitlement program jointly funded by the states and the federal government and plays a significant role in state health care systems; and

WHEREAS, Medicaid is the nation's primary health insurance program for 60 million low-income Americans, including nearly 30 million low-income children and 8 million non-elderly people with disabilities; and

WHEREAS, Medicaid pays for nearly half of all long-term care in the United States; and

WHEREAS, It is essential that Medicaid achieve transformation to become a sustainable, cost-effective health care program; and

WHEREAS, In most states, costs for the Medicaid program are rapidly growing, claiming an increasing share of state budgets and threatening other state programs; and

WHEREAS, Legislators in all states recognize the important role that Medicaid serves as a provider and purchaser of health care services for vulnerable citizens; and

WHEREAS, Under national health care reform, many states will experience an expansion of persons eligible for Medicaid with many of the attendant cost pressures; and

WHEREAS, The situation for individuals under Medicaid with chronic illness and disabilities is particularly fragmented and uncoordinated, with states spending up to 80 percent of their Medicaid budgets on approximately 20 percent of Medicaid beneficiaries whose needs include long-term care services and supports; and

WHEREAS, Reforming and restructuring state Medicaid programs to provide incentives for high quality, efficient and cost-effective care will help contain the growth of the Medicaid program and help ensure that Medicaid does not threaten other essential state services; and

WHEREAS, Managing the care for those with Medicaid through a risk-based system has demonstrated greater budget predictability, more accountability, improved quality of care for the consumer, and more coordination among service providers.

NOW THEREFORE BE IT RESOLVED that the **{insert state legislature}** will seek to strengthen the fiscal solvency of **{insert state}** and improve the health of Americans enrolled in Medicaid by introducing legislation to implement coordinated, risk-based, capitated programs to control costs and improve quality of care for all Medicaid recipients, including those requiring long-term care services.

HHS Task Force
June 29, 2010

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Sen.	Alan	Nunnelee	Mississippi Legislature	New Capitol	PO Box 1018	Jackson	MS	39215-1018	(601) 359-3250	(601) 359-5110	anunnelee@senate.ms.gov
Rep.	Jessica	Upshaw	Mississippi Legislature	747 Kome Drive		Diamondhead	MS	39525	(601) 359-3360	(601) 359-3728	jupshaw@house.ms.gov
Sen.	Michael	Watson	Mississippi Legislature	5402 Hilltop St.		Pascagoula	MS	39567	(601) 359-3234	(601) 359-5345	mwatson@senate.ms.gov
Sen.	Lee	Yancey	Mississippi Legislature	423 Woodlands Circle		Brandon	MS	39047	(601) 359-3250	(601) 359-5110	lyancey@senate.ms.gov
Rep.	Sue	Allen	Missouri Legislature	702 Willow Spring Hill Court		Chesterfield	MO	63017	(573) 751-9765		Sue.Allen@house.mo.gov
Rep.	Cynthia	Davis	Missouri Legislature	201 West Capitol Ave.		Jefferson City	MO	65101	(573) 751-9768	(573) 526-1423	Cynthia.Davis@house.mo.gov
Rep.	Douglas	Ervin	Missouri Legislature	201 West Capitol Ave.		Jefferson City	MO	65101	(573) 751-2238	(573) 522-9320	doug.ervin@house.mo.gov
Rep.	Theodore	Hoskins	Missouri Legislature	8424 January Ave.		Saint Louis	MO	63134-1414	(573) 751-0169	(573) 526-9867	theodore.hoskins@house.mo.gov
Sen.	Roy	Brown	Montana Legislature	P.O. Box 22273		Billings	MT	59104-2273	(406) 444-4800	(406) 444-4875	BROWN.ROY@BRESNAN.NET
Sen.	John	Esp	Montana Legislature	1301 East 6th Ave.		Helena	MT	59620	(406) 444-4800	(406) 444-4875	johnesp2001@yahoo.com
Rep.	Gary	MacLaren	Montana Legislature	429 Curlew Orchard Rd.		Victor	MT	59875	(406) 444-4800	(406) 444-1865	garymaclaren@yahoo.com
Sen.	Tim	Gay	Nebraska Unicameral Legislature	State Capitol, Rm. 1402	P.O. Box 94604	Lincoln	NE	68509	(402) 471-2730	(402) 479-0914	tgay@leg.ne.gov
Sen.	Danielle	Nantkes	Nebraska Unicameral Legislature	State Capitol, Rm. 1008		Lincoln	NE	68509	(402) 471-2720	(402) 479-0946	dnantkes@leg.ne.gov
Sen.	Dave	Pankonin	Nebraska Unicameral Legislature	1445 K Street	Rm. 1529	Lincoln	NE	68509	(402) 471-2613	(402) 479-0902	dpankonin@leg.ne.gov
Assb.	Joe	Hardy	Nevada Legislature	401 South Carson St.		Carson City	NV	89701	(775) 684-8857	(775) 684-8533	jhardy@asm.state.nv.us
Rep.	Jennifer	Coffey	New Hampshire Legislature	107 North Main St.		Concord	NH	3301	(603) 271-2548	(603) 271-3309	jenn.coffey@leg.state.nh.us
Rep.	Susan	Emerson	New Hampshire Legislature	571 NH Route 119		Rindge	NH	3461	(603) 271-2548	(603) 271-3309	susan.emerson@leg.state.nh.us
Rep.	Francine	Wendelboe	New Hampshire Legislature	238 Lower Ox Bow Rd.		New Hampton	NH	3256	(603) 271-3589	(603) 271-3309	mattwenfran@myfairpoint.net
Rep.	Nora	Espinoza	New Mexico Legislature	608 Golondrina		Roswell	NM	88201	(505) 986-4221	(505) 986-4280	noralee@cableone.net
Rep.	Keith	Gardner	New Mexico Legislature	4500 Verde Dr.		Roswell	NM	88201	(505) 986-4757	(505) 986-4610	keith.gardner@nmlegis.gov
Rep.	Julia	Howard	North Carolina General Assembly	330 South Salisbury St.		Mocksville	NC	27028	(919) 733-5904	(919) 733-2599	Juliah@ncleg.net
Rep.	Wil	Neumann	North Carolina General Assembly	3215 Grange Ct.		Belmont	NC	28012	(919) 733-5868	(919) 733-3113	Wiln@ncleg.net
Sen.	Dick	Dever	North Dakota Legislature	1416 Eastwood Street		Bismarck	ND	58504	(701) 328-3373	(701) 328-1997	ddever@nd.gov
Rep.	Chet	Pollert	North Dakota Legislature	560 South Sixth St.		Carrington	ND	58421-2317	(701) 328-3373	(701) 328-1997	cpollert@nd.gov
Rep.	Alon	Wieland	North Dakota Legislature	PO Box 412		West Fargo	ND	58078	(701) 328-2916	(701) 328-1997	awieland@nd.gov
Rep.	Dave	Burke	Ohio Legislature	77 South High St.		Columbus	OH	43215-6111	(614) 466-8147	(614) 719-6983	district83@ohr.state.oh.us
Sen.	Karen	Gillmor	Ohio Legislature	Senate Office Building Room 035		Columbus	OH	43215	(614) 466-8049	(614) 466-7662	SD26@senate.state.oh.us
Rep.	Peggy	Lehner	Ohio Legislature	77 South High St.		Columbus	OH	43215-6111	(614) 644-6008	(614) 719-3591	district37@ohr.state.oh.us
Sen.	Cliff	Branan	Oklahoma Legislature	2300 North Lincoln Blvd.	Rm. 417C	Oklahoma City	OK	73105	(405) 521-5543	(405) 521-5507	branan@oksenate.gov
Rep.	Doug	Cox	Oklahoma Legislature	33471 South 595 Rd.	A7	Grove	OK	74344	(405) 557-7415	(405) 962-7642	dougcox@okhouse.gov
Sen.	Brian	Crain	Oklahoma Legislature	2300 North Lincoln Blvd.	Rm. 417B	Oklahoma City	OK	73105	(405) 521-5620	(405) 530-2302	crain@oksenate.gov
Rep.	Ronald	Peters	Oklahoma Legislature	4432 South Atlanta Pl.		Tulsa	OK	74105-4344	(405) 557-7359	(405) 962-7657	ron-peters@att.net; ronpeters@okhouse.gov
Rep.	Pam	Peterson	Oklahoma Legislature	5126 East 106 St.		Tulsa	OK	74137	(405) 557-7341	(405) 962-7657	pampeterson@okhouse.gov
Rep.	Colby	Schwartz	Oklahoma Legislature	2300 North Lincoln Blvd.	Rm. 329	Oklahoma City	OK	73105	(405) 557-7352	(405) 962-7638	colby.schwartz@okhouse.gov
Rep.	Bill	Kennemer	Oregon Legislature	900 Court St., NE	H-380	Salem	OR	97301	(503) 986-1439	(503) 986-1997	rep.billkennemer@state.or.us
Rep.	Ronald	Maurer	Oregon Legislature	900 Court St., NE	H-372	Salem	OR	97301	(503) 986-1403		rep.ronmaurer@state.or.us
Rep.	James	Thompson	Oregon Legislature	900 Court St. NE	H388	Salem	OR	97301	(503) 986-1423	(503) 986-1167	rep.jimthompson@state.or.us
Sen.	Patrick	Browne	Pennsylvania Legislature	801 Hamilton St.		Allentown	PA	18101	(717) 787-1349	(717) 772-3458	pbrowne@pasen.gov
Rep.	Dick	Hess	Pennsylvania Legislature	451 North Third St.		Harrisburg	PA	17120	(717) 787-7076	(717) 705-1835	dhess@pahousegop.com
Rep.	Katie	TRUE	Pennsylvania Legislature	2962 Kings Ln.		Lancaster	PA	17601	(717) 705-7161	(717) 705-1946	ktrue@pahousegop.com
Sen.	Leo	Blais	Rhode Island Legislature	82 Smith St.	Rm. 120	Providence	RI	2903	(401) 276-2531	(401) 222-2967	lblais@apothecarecs.com
Sen.	Thomas	Alexander	South Carolina Legislature	150 Cleveland Dr.		Walhalla	SC	29691	(803) 212-6220	(843) 825-3948	SGE@scsenate.org
Sen.	Raymond	Cleary	South Carolina Legislature	1625 Glens Bay Rd.		Surfside Beach	SC	29576	(803) 212-6100	(843) 650-0689	rec1313@aol.com
Rep.	Kristopher	Crawford	South Carolina Legislature	728 North Grove Park Dr.		Florence	SC	29501	(803) 734-2992	(803) 734-2925	CrawfordK@schouse.org
Rep.	Rex	Rice	South Carolina Legislature	P.O. Box 1706		Easley	SC	29641	(803) 734-3035	(803) 734-2925	RFR@schouse.org
Sen.	Kathy	Miles	South Dakota Legislature	501 East Capitol Ave.		Pierre	SD	57501	(605) 773-3251	(605) 773-6806	kmiles610@yahoo.com
Rep.	Tim	Rave	South Dakota Legislature	501 East Capitol Ave.		Pierre	SD	57501	(605) 773-3251	(605) 773-6806	trave@alliancecom.net
Rep.	Fred	Romkema	South Dakota Legislature	501 East Capitol Ave.		Pierre	SD	57501-5070	(605) 773-3251	(605) 773-6806	rep.romkema@state.sd.us
Rep.	Manford	Steele	South Dakota Legislature	3220 West Zephyr Place #1		Sioux Falls	SD	57108	(605) 335-7036	(605) 773-6806	rep.steele@state.sd.us
Rep.	Joseph	Armstrong	Tennessee Legislature	25 Legislative Plaza		Nashville	TN	37243	(615) 741-0768	(615) 253-0316	rep.joe.armstrong@capitol.tn.gov
Sen.	Diane	Black	Tennessee Legislature	5 Legislative Plaza		Nashville	TN	37243	(615) 741-1999	(615) 253-0207	sen.diane.black@capitol.tn.gov
Rep.	Jimmy	Eldridge	Tennessee Legislature	War Memorial Bldg.	Rm. 208	Nashville	TN	37243	(615) 741-7475	(615) 253-0373	rep.jimmy.eldridge@capitol.tn.gov
Rep.	Debra	Maggart	Tennessee Legislature	7th Ave. North		Nashville	TN	37243	(619) 741-3893	(615) 253-0350	rep.debra.young.maggart@capitol.tn.gov
Rep.	David	Shepard	Tennessee Legislature	Legislative Plaza	Ste. 34	Nashville	TN	37243-0169	(615) 741-3513	(615) 253-0244	rep.david.shepard@capitol.tn.gov
Rep.	Drew	Darby	Texas Legislature	1100 Congress Avenue		Austin	TX	78701	(512) 463-0331	(512) 499-3978	district72.darby@house.state.tx.us
Rep.	Susan	King	Texas Legislature	1100 Congress Avenue		Austin	TX	78701	(512) 463-0718	(512) 463-0994	susan.king@house.state.tx.us
Rep.	Lois	Kolkhorst	Texas Legislature	P.O. Box 2910	Rm. E2.318	Austin	TX	78768-2910	(512) 463-0600	(512) 463-5240	lois.kolkhorst@house.state.tx.us
Rep.	Mark	Shelton	Texas Legislature	PO Box 2910		Austin	TX	78768-2910	(512) 463-1000	(512) 463-5896	mark.shelton@house.state.tx.us;Clayton.Stewart@house.state.tx.us; Clayton.Stewart@house.state.us
Sen.	Carlos	Uresti	Texas Legislature	1100 Congress Ave.	Rm. E1.810	Austin	TX	78701	(512) 463-0119	(512) 463-1017	carlos.uresti@senate.state.tx.us
Rep.	John	Zerwas	Texas Legislature	1100 Congress Ave.	Rm. E2.316	Austin	TX	78701	(512) 463-0657	(512) 236-0713	john.zerwas@house.state.tx.us
Mr.	Jeff	Drozda	UnitedHealth Group	2 Independence Pointe	Suite 100	Greenville	SC	29615	(864) 213-2786	(317) 290-8517	jeffery_a_drozda@uhc.com
Rep.	Bradley	Daw	Utah Legislature	842 East 280 South		Orem	UT	84097	(801) 538-1029	(801) 326-1544	bdaw@utah.gov
Rep.	Francis	Gibson	Utah Legislature	P.O. Box 145030	Suite 350	Salt Lake City	UT	84114-5030	(801) 538-1029	(801) 326-1544	fgibson@utah.gov
Rep.	Eric	Hutchings	Utah Legislature	5438 West Stoney Ridge Circle		Kearns	UT	84118	(801) 538-1029	(801) 326-1544	ehutchings@utah.gov
Rep.	Mary	Morrissey	Vermont Legislature	228 Dewey St.		Bennington	VT	5201	(802) 828-2247	(802) 828-2424	mmorrissey@leg.state.vt.us
Sen.	Kevin	Mullin	Vermont Legislature	118 Ox Yoke Dr.		Rutland	VT	5701	(802) 828-2228	(802) 828-2424	kjmbjm@aol.com

HHS Task Force
June 29, 2010

Rep.	Patricia	O'Donnell	Vermont Legislature	51 Southern Heights Dr.		Vernon	VT	05354-9614	(802) 828-2247	(802) 828-2424	podonnell@leg.state.vt.us
Del.	S. Chris	Jones	Virginia General Assembly	P.O. Box 5059		Suffolk	VA	23435-0059	(804) 698-1076	(804) 698-6776	DelCJones@house.virginia.gov
Sen.	Stephen	Martin	Virginia General Assembly	P.O. Box 396		Richmond	VA	23218	(804) 698-7511	(804) 698-7651	district11@senate.virginia.gov
Sen.	Stephen	Newman	Virginia General Assembly	3550 Mayflower Dr.	Ste. A	Lynchburg	VA	24501	(804) 698-7523	(804) 698-7651	district23@senate.virginia.gov
Rep.	Barbara	Bailey	Washington Legislature	406 John L. O'Brien Building	P.O. Box 40600	Olympia	WA	98504-0600	(360) 786-7914	(360) 786-1066	bailey.barbara@leg.wa.gov
Rep.	Doug	Ericksen	Washington Legislature	425B Legislative Building	PO Box 40600	Olympia	WA	98504	(360) 786-7980	(360) 786-1066	ericksen.doug@leg.wa.gov
Rep.	Jaime	Herrera	Washington Legislature	416 John L. O'Brien Building	PO Box 40600	Olympia	WA	98504	(360) 786-7850	(360) 786-7317	herrera.jaime@leg.wa.gov
Sen.	Linda	Parlette	Washington Legislature	625 Okanogan Avenue	Suite 301	Wenatchee	WA	98801	(360) 786-7622	(360) 786-1266	parlette.linda@leg.wa.gov
Rep.	Judy	Warnick	Washington Legislature	403 John L. O'Brien Building	PO Box 40600	Olympia	WA	98504-0600	(360) 786-7932	(360) 786-7317	warnick.j@leg.wa.gov
Del.	Ronald	Walters	West Virginia Legislature	P.O. Box 3665		Charleston	WV	25336-3665	(304) 340-3194	(304) 342-8342	rwalters@sfainc.com; ronwalte@mail.wvnet.edu
Rep.	Scott	Newcomer	Wisconsin Legislature	P.O. Box 8953		Madison	WI	53708	(608) 266-3007	(608) 282-3633	Rep.Newcomer@legis.wisconsin.gov
Rep.	Kitty	Rhoades	Wisconsin Legislature	P.O. Box 8953	Rm. 115 West	Madison	WI	53708	715-338-2725	(608) 282-3630	kittyrhoades@comcast.net
Rep.	Leah	Vukmir	Wisconsin Legislature	P.O. Box 8953		Madison	WI	53708	(608) 266-9180	(608) 282-3614	rep.vukmir@legis.state.wi.us
Rep.	Kathy	Davison	Wyoming Legislature	Box 602		Kemmerer	WY	83101	(307) 777-7852	(307) 777-5466	kdavison@wyoming.com
Sen.	John	Hastert	Wyoming Legislature	Capitol Bldg.	Rm. 213	Cheyenne	WY	82001	(307) 777-7881		jhastert2@wyoming.com
Rep.	Lori	Millin	Wyoming Legislature	308 Stetson Dr.		Cheyenne	WY	82009	(307) 777-7852	(307) 777-5466	lorimillin@bresnan.net
Ms.	Christie	Herrera	ALEC	1101 Vermont Avenue, N.W.	11th Floor	Washington	DC	20005	202-742-8505		christie@alec.org
Ms.	Monica	Mastracco	ALEC	1101 Vermont Avenue, N.W.	11th Floor	Washington	DC	20005	202-742-8525	(202) 466-3801	mmastracco@alec.org
Mr.	Jonathan	Moody	ALEC	1101 Vermont Ave.	11th Floor	Washington	DC	20005	(202) 742-8516	(202) 466-3801	jmoody@alec.org
Mr.	Ronald	Scheberle	ALEC	2601 Brookside Drive		Irving	TX	75063	(214) 557-6769	(972) 869-2258	ronscheberle@sbcglobal.net

Health and Human Services Task Force Meeting
ALEC's 2010 Spring Task Force Summit
April 23, 2010
Meeting Minutes

Legislative Members in Attendance (13)
Sen. Thomas Alexander, South Carolina
Rep. Sue Allen, Missouri
Rep. Cynthia Davis, Missouri
Rep. David Frizzell, Indiana
Rep. David Heaton, Iowa
Rep. Bill Kennemer, Oregon
Rep. Peggy Lehner, Ohio
Rep. Dolores Mertz, Iowa
Rep. Pam Peterson, Oklahoma
Rep. Fred Romkema, South Dakota
Rep. Scott Schwab, Kansas
Rep. Linda Upmeyer, Iowa
Rep. Francine Wendelboe, New Hampshire

Legislative Alternates in Attendance (0)

Private Sector Members in Attendance (31)
Allergan: Patricia Cannon
Alliance of Health Care Sharing Ministries: James Lansberry
American Physical Therapy Association: Angela Chasteen
America's Health Insurance Plans: Dianne Bricker
AMERIGROUP: Calise Munoz
Astellas: James Turner
AstraZeneca: Carol Curtis, Margaret Propes
Bayer: Gary Barrett, Mike Birdsong
Celgene: Greg Chesmore
Daiichi Sankyo: Julie Vojtech
Doctor-Patient Medical Association: Kathryn Serkes
The Doctors Company: Sal Bianco
Express Scripts: Michael Harrold
GlaxoSmithKline: Sandie Benin, Mary Koenecke
Guarantee Trust Life Insurance Company: Marianne Eterno
Heartland Institute: Peter Fotos
John Locke Foundation: Joe Coletti

Johnson & Johnson: Jeff Buel
Mackinac Center for Public Policy: Jack McHugh
Medco: Andrew Friedell
MedImmune: Elizabeth Brunsvold
Medtronic: Laura Bordelon
Merck: Heather Densmore, Marlene Sanders, James Vance
Pacific Research Institute: John Graham
Pfizer: Josh Brown, Michael Hubert
Purdue Pharma.: Brian Rosen
Reynolds American: Greg Osmon
Takeda: Marilyn Vetter
Teva: Jake Hansen, Jerry Moore, Steven Rauschenberger, Philip Smith
Texas Public Policy Foundation: Ryan Brannan
Wal-Mart: Laurie Smalling

Invited Guests in Attendance (1)
Dave Roland, Show Me Institute

Others in Attendance (3)
Rep. Jim Clark, Idaho
Rep. Eric Turner, Indiana
Sen. Susan Wagle, Kansas

Staff in Attendance (3)
Christie Herrera, ALEC HHS Task Force Director
Jonathan Moody, ALEC Director of Donor Relations
Dave Myslinski, ALEC Education Task Force Director

*** * ***
Meeting began at 2:00 p.m.

The meeting began with an introduction of the HHS Task Force Executive Committee; roundtable introductions of HHS Task Force meeting attendees; recognition of new HHS Task Force Member, the Doctor-Patient Medical Association, and returning member Pfizer; and a unanimous approval of the minutes from ALEC's 2009 States and Nation Policy Summit.

HHS Task Force Director Christie Herrera updated task force members on ALEC's Health Reform Initiative and announced that HHS Legislative Manager Dave Myslinski would be leaving the HHS Task Force to direct ALEC's Education Task Force.

HHS Task Force members participated in a roundtable discussion, "ALEC's *Freedom of Choice in Health Care Act*: How Might It Fare in Court?" with Show Me Institute Policy Analyst Dave Roland, and heard policy updates from Pacific Research Institute's John Graham ("Taxing Health Insurance: How Much Do States Earn?") and America's Health Insurance Plans' Dianne Bricker ("Discounted Fees for Dental Services").

HHS Task Force members considered the *Resolution on Cord and Placenta Blood Banking and Research*, sponsored by Indiana Representative Dave Frizzell and Celgene's Greg Chesmore. After discussion, South Dakota Representative Fred Romkema called the question, and John Locke Foundation's Joe Coletti seconded. The public sector vote was 14 Yes, 0 No; the private sector vote was 24 Yes, 0 No. The *Resolution on Cord and Placenta Blood Banking and Research* was approved.

HHS Task Force members considered the *Patients First Medicaid Reform Act*, sponsored by John Locke Foundation's Joe Coletti. During discussion, the Alliance of Health Care Sharing Ministries' James Lansberry motioned to amend the *Act* by removing Section 6. The amendment was called by Indiana Representative Dave Frizzell and seconded by Kansas Representative Scott Schwab. The amendment failed on a public sector vote of 5 Yes, 7 No. Missouri Representative Sue Allen then motioned to amend the language regarding the percentage of leftover account funds available for beneficiary use. The amendment was called by Missouri Representative Sue Allen and seconded by The Doctors Company's Sal Bianco. The amendment failed on a public sector vote of 3 Yes, 5 No. The Alliance for Health Care Sharing Ministries' James Lansberry then called the original question, and New Hampshire Representative Fran Wendelboe seconded. The public sector vote was 6 Yes, 5 No; the private sector vote was 9 Yes, 10 No. The *Patients First Medicaid Reform Act* failed, and the sponsor indicated he would incorporate members' comments in a revised draft to be considered at ALEC's 37th Annual Meeting.

The meeting adjourned at 4:30 p.m.

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AMERICAN LEGISLATIVE EXCHANGE COUNCIL

ALEC

Mission Statement

The American Legislative Exchange Council's mission is…

To advance the Jeffersonian Principles of free markets, limited government, federalism, and individual liberty through a nonpartisan public-private partnership among America's state legislators, concerned members of the private sector, the federal government, and the general public.

To promote these principles by developing policies that ensure the powers of government are derived from, and assigned to, first the People, then the States, and finally the Federal Government.

To enlist state legislators from all parties and members of the private sector who share ALEC's mission.

To conduct a policy making program that unites members of the public and private sector in a dynamic partnership to support research, policy development, and dissemination activities.

To prepare the next generation of political leadership through educational programs that promote the principles of Jeffersonian democracy, which are necessary for a free society.

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

SCHOLARSHIP POLICY BY MEETING

ALEC Spring Task Force Summit:

1. ***Spring Task Force Summit Reimbursement Form:*** ALEC Task Force Members are reimbursed by ALEC up to $350.00 for travel expenses. Receipts must be forwarded to the ALEC Policy Coordinator and approved by the Director of Policy.
2. ALEC Task Force Members' room & tax fees for a two-night stay are covered by ALEC.
3. *Official Alternate Task Force Members* (chosen by the State Chair and whose names are given to ALEC more than 35 days prior to the meeting to serve in place of a Task Force Member who cannot attend) are reimbursed in the same manner as Task Force Members.
4. ***State Scholarship Reimbursement Form***: Any fees above $350, or expenses other than travel and room expenses can be submitted by Task Force Members for payment from their state scholarship account upon the approval of the State Chair. Receipts must be submitted to the State Chair, who will submit the signed form to the Director of Membership.
5. *Non-Task Force Members* can be reimbursed out of the state scholarship fund upon State Chair approval. Receipts must be submitted to the State Chair, who will submit the appropriate signed form to the Director of Membership.

ALEC Annual Meeting:

State Scholarship Reimbursement Form: State scholarship funds are available for reimbursement by approval of your ALEC State Chair. Expenses are reimbursed after the conference, and may cover the cost of travel, room & tax, and registration. Receipts are to be submitted to the State Chair, who will then submit the signed form to the Director of Membership.

ALEC States & Nation Policy Summit:

1. ***States & Nation Policy Summit Reimbursement Form***: ALEC offers two scholarships per state to cover the cost of travel, room & tax, and registration not to exceed $1,000.00 per person for a total of $2,000.00 per state. ALEC scholarship recipients must be named by the ALEC State Chair. Expenses are submitted to the State Chair and reimbursed after the conference. The State Chair submits the signed form to the Director of Membership.
2. ***State Scholarship Reimbursement Form***: Any other fees or payments must come out of the state scholarship account, with the approval of the State Chair. Receipts must be submitted to the State Chair, who submits the signed form to the Director of Membership.

ALEC Academies:

Academy Reimbursement Form: Attendees of ALEC Academies are reimbursed by the Task Force Committee hosting the Academy. Attendees will receive a form at the Academy, and will be reimbursed up to $500.00 for travel, and room & tax fees for a two-night stay by ALEC. Receipts must be forwarded to the appropriate Task Force Director and approved by the Director of Policy.

American Legislative Exchange Council
TASK FORCE OPERATING PROCEDURES

I. MISSION OF TASK FORCES

Assume the primary responsibility for identifying critical issues, developing ALEC policy, and sponsoring educational activities which advance the Jeffersonian principles of free markets, limited government, federalism, and individual liberty. The mission will be accomplished through a non-partisan, public and private partnership between ALEC's legislative and private sector members in the specific subject areas assigned to the Task Force by the Board of Directors.

II. TASK FORCE RESPONSIBILITIES

A. Task Forces have the primary responsibility for identifying critical issues and developing ALEC's official policy statements and model legislation appropriate to the specific subject areas of the Task Force.

B. Task Forces serve as forums for an exchange of ideas and sharing of experiences between ALEC's state legislator and private sector members.

C. Task Forces are responsible for developing and sponsoring the following educational activities appropriate to the specific subject area of the Task Force:

- publications that express policy positions, including, but not limited to State Factors and Action Alerts;
- educational communication and correspondence campaigns;
- issue specific briefings, press conferences and press campaigns;
- witness testimony and the activities of policy response teams;
- workshops at ALEC's conferences; and
- specific focus events.

D. The Executive Director is to ~~Task Forces are responsible for~~ develop~~ing~~ an annual budget~~s,~~ which shall include expenses associated with Task Force meetings and educational activities. A funding mechanism to finance all meetings and educational activities proposed by Task Forces must be available before they can be undertaken.

III. GENERAL PROCEDURES

A. Requests from ALEC members for policy statements, model legislation and educational activities shall be directed by the Executive Director to the appropriate Task Force, or the Board of Directors if the issue does not fall within the jurisdiction of any Task Force. The appropriate Public and Private Sector Task Force Co-Chairs determine the agenda for each Task Force meeting, and the meetings will be called and conducted in accordance with these Operating Procedures.

The Director of Policy with the consent of the Executive Director assigns a model bill or resolution to the most appropriate Task Force based on Task Force content and prior jurisdictional history 35 days before a Task Force Meeting. All Task Force Co-Chairs will be provided an email or fax summary of all model bills and resolutions 35 days before the Task Force meeting

If both the Co-Chairs of a Task Force are in agreement that they should have jurisdiction on model legislation or a resolution, the legislation or resolution will be considered by the Task Force. If the other Task Force Co-Chairs believe they should have jurisdiction or if the author of the model bill or resolution does not agree on the jurisdictional assignment of the bill, they will have 10 days after the 35-day mailer deadline to submit in writing or by electronic appeal to the Director of Policy their intent to challenge the jurisdiction assignment. The Director of Policy will notify the Executive Director who will in turn notify the National Chair and the Private Enterprise Board Chair. The National Chair and the Private Enterprise Board Chair will in turn refer the matter in question to the Board of Directors Task Force Board Committee. The Director of Policy will establish a conference call for the Task Force Board Committee co- chairs, the author, the affected Task Force Co-Chairs and the Director of Policy at a time convenient for all participants.

The Task Force Board Committee Co-Chairs shall listen to the jurisdictional dispute by phone or in person within 10 days of the request. If both Task Force Board Committee Co-Chairs are in agreement that the Director of Policy made an incorrect jurisdictional referral, only then will the model bill or resolution be reassigned to a committee as they specify once agreed upon by the National Chair and the Private Enterprise Board Chair. The bill or model resolution is still eligible to be heard in whatever Task Force it is deemed to be assigned to as if submitted to the correct Task Force for the 35-day mailer. The National Chair and the Private Enterprise Board Chair decision is final on this model bill or resolution.

Joint referral of model legislation and/or resolutions are allowed if all the affected Task Force Co-Chairs agree. All model legislation and resolutions that have been referred to, more than one Task Force must pass the identical language in both Task Forces within two consecutive Task Force meetings. It is at the Task Force

Co-Chairs discretion how they will handle the hearings of the model legislation or resolution. Both sets of co-chairs have the ability to call a working group, subcommittee, or simply meet consecutively or concurrently if necessary.

If the Task Force co-chairs both agree to waive jurisdiction, they may do so as long as another Task Force still has jurisdiction.

The National Chair and the Private Sector Board Chair will rely upon the Task Force Board Committee Co-Chairs for advice and recommendations on model legislation or resolutions when no jurisdiction in any of the existing Task Forces in operation can be found. The Task Force Board Committee Co-Chairs will work with the Executive Director and the Director of Policy to identify public and private sector Task Force members (not alternates) from the existing Task Forces should their expertise be of assistance to the Task Force Board Committee in reaching a determination and recommendation for approval by the National Chair and the Private Enterprise Board Chair.

B. The National Chair and the Private Sector Board Chair will rely upon the Task Force Board Committee Co-Chairs for advice and recommendations on model legislation or resolutions when no jurisdiction in any of the existing Task Forces in operation can be found. The Task Force Board Committee Co-Chairs will work with the Executive Director and the Director of Policy to identify public and private sector Task Force members (not alternates) from the existing Task Forces should their expertise be of assistance to the Task Force Board Committee in reaching a determination and recommendation for approval by the National Chair and the Private Enterprise Board Chair.

C. The Board of Directors shall have ultimate authority over Task Force procedures and actions including the authority to create, to merge or to disband Task Forces and to review Task Force actions in accordance with these Operating Procedures. Nothing in these Operating Procedures prohibits the Board of Directors from developing ALEC policy; however, such a practice should be utilized only in exceptional circumstances. Before the policy is adopted by the Board of Directors, it should be sent to the Public and Private Sector Task Force Co-Chairs under whose jurisdiction the matter falls for review and comment back to the Board of Directors.

D. The operating cycle of a Task Force is two years. A new operating cycle begins on January 1 of each odd numbered year and ends on December 31 of the following even numbered year. Task Force activities shall be planned and budgeted on an annual basis within each two-year operating cycle.

E. ~~At the ALEC Annual Meeting, each Task Force will be responsible for determining an operating budget for the succeeding calendar year. The Executive Director will notify the Task Force Co-Chairs, at the ALEC Annual Meeting, what inflation factor will be used by the Task Force to determine the operating~~

~~and programming budgets. Task Force membership and budget information will be reported to the Executive Director by the Public and Private Sector Task Force Co-Chairs. The Executive Director will present this information to the Board of Directors at its regular fall meeting.~~

F. If a Task Force is unable to develop an operating budget, the Board of Directors will determine whether to continue the operations of the Task Force. This determination will be made according to: (1) the level of membership on the Task Force, and (2) the need for continued services developed by the Task Force for ALEC.

G. The Board of Directors shall have the authority to allocate limited general support funds to finance the annual operating budget of Task Forces that meet the requirements prescribed in Section III (E). The Executive Director shall determine, and report to the Board of Directors, the amount of general support funds available to underwrite such Task Forces.

IV. MEMBERSHIP AND MEMBER RESPONSIBILITIES

A. The membership of a Task Force consists of legislators who are members in good standing of ALEC and are duly appointed to the Task Force, in accordance with Section VI (A) and private sector organizations that are full members of ALEC, contribute to the assessment for the Task Force operating budget, and are duly appointed to the Task Force, in accordance with Section VI (B). Private sector organizations that were full members of ALEC and contributed the assessment for the Task Force's operating budget in the previous year, can be appointed to the Task Force for the current year, conditional upon renewal of full ALEC membership and receipt of the current year's assessment for the Task Force operating budget prior to March 31st, unless an alternative date has been approved by the Executive Director.

B. Each Task Force shall have <u>least</u> two Co-Chairs; a Public Sector Task Force Co-Chair and a Private Sector Task Force Co-Chair. The Public Sector Task Force Co-Chair must be a member of the Task Force and appointed in accordance with Section VI (A). The Private Sector Co-Chair must represent a private sector member of the Task Force and be appointed in accordance with Section VI(B). The Co-Chairs shall be responsible for:

(1) calling the Task Force and the Executive Committee meetings to order, setting the agenda and co-chairing such meetings;
(2) appointing and removing legislators and private sector members to and from the Task Force Executive Committee and subcommittees;
(3) creating subcommittees, and determining each subcommittee's mission, membership limit, voting rules, deadlines, and term of service; and

(4) selecting Task Force members to provide support for and against Task Force policies during formal Board reviews.

C. Each Task Force shall have an Executive Committee appointed by the Public and Private Sector Task Force Co-Chairs that is appropriate in number to carry out the work product and strategic plan of ALEC and the Task Force. The Executive Committee shall consist of the Public Sector Task Force Co-chair, the Private Sector Task Force Co-Chair, the subcommittee co-chairs, and the remainder will be an equal number of legislative and private sector Task Force members. The Executive Committee will be responsible for determining the operating budget and proposing plans, programs and budgets for the succeeding year in accordance with (Section V (B); determining if a proposed educational activity conforms to a previously approved model bill, resolution or policy statement in accordance with (Section IX (F); and determining if an emergency situation exists that justifies waiving or reducing appropriate time limits in accordance with (Section VIII (H)).

D. Each Task Force may have any number of subcommittees, consisting of Task Force members and advisors to focus on specific areas and issues and make policy recommendations to the Task Force. The Task Force Co-chairs, shall create subcommittees and determine each subcommittee's mission, membership limit, voting rules, deadlines, and term of service. Any model bill, resolution or policy statement approved by a subcommittee must be approved by the Task Force before it can be considered official ALEC policy.

E. Each Task Force may have advisors, appointed in accordance with Section VI (G). Advisors shall assist the members and staff of the Task Force. They shall be identified as advisors on official Task Force rosters, included in all official Task Force mailings and invited to all Task Force meetings. Advisors may also have their expenses paid at Task Force meetings covered by the Task Force operating budget with the approval of the Task Force Co-Chairs. An advisor cannot be designated as the primary contact of a private sector Task Force member, cannot be designated to represent a private sector Task Force member at a Task Force, Executive Committee, or subcommittee meeting, and cannot offer or vote on any motion at a Task Force, Executive Committee, or subcommittee meeting.

V. Task Force Budgets

A. Each Task Force shall develop and operate a yearly budget to fund meetings.

B. The operating budget shall be used primarily to cover expenses for Task Force meetings, unless specific funds within the budget are authorized for other use by the Task Force. The operating budget shall be assessed equally among the private sector members of the Task Force. The Executive Director, in consultation with the Task Force Co-Chairs shall determine which costs associated with each meeting will be reimbursed from the operating budget. Any funds remaining in a

Task Force's operating budget at the end of a year are transferred to ALEC's general membership account.

C. The operating budget shall not be used to cover Task Force meeting expenses associated with alternate task force members' participation, unless they are appointed by their State Chair to attend the Spring Task Force Summit with the purpose to serve in place of a Task Force Member who is unable to attend. Task Force meeting expenses of alternate task force members shall be covered by their state's scholarship account.

D. The programming budget shall be used to cover costs associated with educational activities. Contributions to the programming budget are separate, and in addition to operating budget contributions and annual general support/membership contributions to ALEC. The Executive Director shall determine the contribution required for each educational activity.

VI. PROCESS FOR SELECTING TASK FORCE MEMBERS, CHAIRS, COMMITTEES AND ADVISORS

A. Prior to February 1 of each odd-numbered year, the current and immediate past National chairman will jointly select and appoint in writing three legislative members and three alternates to the Task Force who will serve for the current operating cycle, after receiving nominations from ALEC's Public and Private State Chairs, the Executive Director and the ALEC Public and Private Sector members of the Board. At any time during the year, the National Chairman may appoint in writing new legislator members to each Task Force, except that no more than three legislators from each state may serve as members of any Task Force, no legislator may serve on more than one Task Force and the appointment cannot be made earlier than thirty days after the new member has been nominated. In an effort to ensure the nonpartisan nature of each Task Force, it is recommended that no more than two legislators of any one political party from the same state be appointed to serve as members of any Task Force. A preference will be given to those ALEC legislator members who serve on or chair the respective Committee in their state legislature. A preference will be given to legislators who sponsor ALEC Task Force model legislation in the state legislature.

B. Prior to January 10 of each odd-numbered year, the current and immediate past National Chairman will jointly select and appoint in writing the Task Force Chair who will serve for the current operating cycle, after receiving nominations from the Task Force. Nominations will be requested by the outgoing Task Force Chair and may be placed in rank order prior to transmittal to the Executive Director no later than December 1 of each even-numbered year. No more than five names may be submitted in nomination by the outgoing Task Force chair. The current and immediate past National Chairmen will jointly make the final selection, but

should give strong weight to the recommendations of the outgoing Task Force Chair. In an effort to empower as many ALEC leaders as possible, State Chairs and members of the Board of Directors will not be selected as Task Force Chairs. Task Force Chairs shall serve for one operating cycle term. Where special circumstances warrant, the current and immediate past National Chairmen may reappoint a Task Force Chair to a second operating cycle term.

C. Prior to February 1 of each odd numbered year, the Public and Private Sector Task Force Co-Chairs will select and appoint in writing the legislative and private sector members of the Task Force Executive Committee, who will serve for the current operating cycle. The Public and Private Sector Task Force Co-Chairs will select and appoint in writing the legislative and private sector members and advisors to any subcommittee.

D. Prior to February 1 of each year, the Private Enterprise Board Chair and the immediate past Private Enterprise Board Chair will select and appoint in writing the private sector members to the Task Force who will serve for the current year. The appointment letter shall be mailed to the individual designated as the primary contact for the private sector entity. At any time during the year, the Chair of the Private Enterprise Board may appoint in writing new private sector members to each Task Force, but no earlier than thirty days after the new member has qualified for full membership in ALEC and contributed the assessment for the appropriate Task Force's operating budget.

E. Prior to January 10 of each odd-numbered year, the Chair of the Private Enterprise Board and the immediate past Private Enterprise Board Chair will select and appoint in writing the Task Force Private Sector Co-Chair who will serve for the current operating cycle, after receiving nominations from the Task Force. Nominations will be requested by the outgoing Task Force Private Sector Chair and may be placed in rank order prior to transmittal to the Chair of the Private Enterprise Board. The Chair and the immediate past Chair of the Private Enterprise Board will make the final selection, but should give strong weight to the recommendations of the outgoing Private Sector Task Force Co-Chair. In an effort to empower as many ALEC private sector members as possible, Private Enterprise State Chairs and members of the Private Enterprise Board will not be selected as Private Sector Task Force Co-Chairs. Private Sector Task Force Co-Chairs shall serve for one operating cycle term. Where special circumstances warrant, the current and immediate past Chair of the Private Enterprise Board may reappoint a Task Force Private Sector Chair to a second operating cycle term.

F. Prior to February 1 of each odd-numbered year, the Task Force Private Sector Co-Chair will select and appoint in writing the private sector members of the Task Force Executive Committee, who will serve for the current operating cycle. The Task Force Private Sector Co-Chair shall select and appoint in writing the private sector members of any subcommittees.

G. The Public and Private Sector Task Force Co-Chairs, may jointly appoint subject matter experts to serve as advisors to the Task Force. The National Chair and the Private Enterprise Board Chair may also jointly recommend to the Task Force Co-Chairs subject matter experts to serve as advisors to the Task Force.

VII. REMOVAL AND VACANCIES

A. The National Chair may remove any Public Sector Task Force Co-Chair from his position and any legislative member from a Task Force with or without cause. Such action will not be taken except upon thirty days written notice to such Chair or member whose removal is proposed. For purposes of this subsection, cause may include failure to attend two consecutive Task Force meetings.

B. The Public Sector Task Force Co-Chair may remove any legislative member of an Executive Committee or subcommittee from his position with or without cause. Such action shall not be taken except upon thirty days written notice to such member whose removal is proposed. For purposes of this subsection, cause may include failure to attend two consecutive meetings.

C. The Chairman of the Private Enterprise Board may remove any Private Sector Task Force Co-Chair from his position and any private sector member from a Task Force with cause. Such action shall not be taken except upon thirty days written notice to such Chair or member whose removal is proposed. For purposes of this subsection, cause may include but is not limited to the non-payment of ALEC General Membership dues and the Task Force dues. .

D. The Private Sector Task Force Co-Chair may remove any private sector member of an Executive Committee or subcommittee from his position with cause. Such action shall not be taken except upon thirty days written notice to such member whose removal is proposed. For purposes of this subsection, cause may include but is not limited to the non-payment of ALEC General Membership dues and the Task Force dues.

E. The Public and Private Sector Task Force Co-Chairs may remove an advisor from his position with or without cause. Such action shall not be taken except upon thirty days written notice to such advisor whose removal is proposed.

F. Any member or advisor may resign from his position as Public Sector Task Force Co-Chair, Private Sector Task Force Co-Chair, public or private sector Task Force member, Task Force advisor, Executive Committee member or subcommittee member at any time by writing a letter to that effect to the Public Sector and Private Sector Task Force Co-Chairs. The letter should specify the effective date of the resignation, and if none is specified, the effective date shall be the date on which the letter is received by the Public and Private Task Force Co-Chairs.

G. All vacancies for Public Sector Task Force Co-Chair, Private Sector Task Force Co-Chair, Executive Committee member and subcommittee member shall be filled in the same manner in which selections are made under Section VI. All vacancies to these positions must be filled within thirty days of the effective date of the vacancy.

VIII. MEETINGS

A. Task Force meetings shall only be called by the joint action of the Public and Private Sector Task Force Co-Chairs. Task Force meetings cannot be held any earlier than thirty-five days after being called, unless an emergency situation has been declared pursuant to Section VIII(H), in which case Task Force meetings cannot be held any earlier than ten days after being called. It is recommended that, at least once a year, the Task Forces convene in a common location for a joint Task Force Summit. Executive Committee meetings shall only be called by the joint action of the Public and Private Sector Task Force Co-Chairs and cannot be held any earlier than three days after being called, unless the Executive Committee waives this requirement by unanimous consent.

B. At least forty-five days prior to a task force meeting any model bill, resolution or policy must be submitted to ALEC staff that will be voted on at the meeting. At least thirty-five days prior to a Task Force meeting, ALEC staff shall distribute copies of any model bill, resolution or policy statement that will be voted on at that meeting. This requirement does not prohibit modification or amendment of a model bill, resolution or policy statement at the meeting. This requirement may be waived if an emergency situation has been declared pursuant to Section VIII(H).

C. All Task Force meetings are open to registered attendees and invited guests of ALEC meetings and conferences. Only regular Task Force Members may introduce any resolution, policy statement or model bill._ Only Task Force members will be allowed to participate in the Task Force meeting discussions and be seated at the table during Task Force meetings, unless otherwise permitted by the Public and Private Sector Task Force Co-Chairs.

D. ALEC private sector member organizations may only be represented at Task Force and Executive Committee meetings by the individual addressed in the appointment letter sent pursuant to Section VI(D) or a designee of the private sector member. If someone other than the individual addressed in the appointment letter is designated to represent the private sector member, the designation must be submitted in writing to the Public and Private Sector Task Force Co-Chairs before the meeting, and the individual cannot represent any other private sector member at the meeting.

E. All Task Force and Executive Committee meetings shall be conducted under the guidelines of Roberts Rules of Order, except as otherwise provided in these Operating Procedures. A copy of the Task Force Operating Procedures shall be included in the briefing packages sent to the Task Force members prior to each meeting.

F. A majority vote of legislative members present and voting and a majority vote of the private sector members present and voting, polled separately, are required to approve any motion offered at a Task Force or Executive Committee meeting. A vote on a motion to reconsider would be only with the sector that made the motion. Members have the right, in a voice vote, to abstain and to vote present by roll-call vote. In all votes a member can change their vote up until the time that the result of the vote is announced. Only duly appointed members or their designee as stated in Section VIII (D) that are present at the meeting may vote on each motion. No proxy, absentee or advance voting is allowed.

G. The Public Sector Task Force Co-Chair and the Private Sector Task Force Co-Chair, with the concurrence of a majority of the Executive Committee, polled in accordance with Section VIII (F), may schedule a Task Force vote by mail or ~~fax~~ any form of electronic communication on any action pertaining to policy statements, model legislation or educational activity. The deadline for the receipt of votes can be no earlier than thirty-five days after notification of the vote is mailed or ~~faxed~~ notified by any form of electronic communication, unless an emergency situation is declared pursuant to Section VIII (H), in which case the deadline can be no earlier than ten days after notification is mailed or ~~faxed~~ notified by any form of electronic communication. Such votes are exempt from all rules in Section VIII, except: (1) the requirement that copies of model legislation and policy statements be mailed or ~~faxed~~ notified by any form of electronic communication with the notification of the vote and (2) the requirement that a majority of legislative members voting and a majority of the private sector members voting, polled separately, is required to approve any action by a Task Force.

H. For purposes of Sections VIII(A), (B) and (G), an emergency situation can be declared by:

(1) Unanimous vote of all members of the Task Force Executive Committee present at an Executive Committee meeting prior to the meeting at which the Task Force votes on the model bill, resolution or policy statement; or

(2) At least three-fourth majority vote of the legislative and private sector Task Force members (voting in accordance with Section VIII (F)) present at the meeting at which the members vote on the model bill, resolution or policy statement.

I. Ten Task Force members shall constitute a quorum for a Task Force meeting. One-half of the legislative and one-half of the private sector members of an Executive Committee shall constitute a quorum for an Executive Committee meeting.

IX. *REVIEW AND ADOPTION PROCEDURES*

A. All Task Force policy statements, model bills or resolutions shall become ALEC policy either: (1) upon adoption by the Task Force and affirmation by the Board of Directors or (2) thirty days after adoption by the Task Force if no member of the Board of Directors requests, within those thirty days, a formal review by the Board of Directors. General information about the adoption of a policy position may be announced upon adoption by the Task Force.

B. The Executive Director shall notify the Board of Directors of the approval by a Task Force of any policy statement, model bill or resolution within ten days of such approval. Members of the Board of Directors shall have thirty days from the date of Task Force approval to review any new policy statement, model bill or resolution prior to adoption as official ALEC policy. Within those thirty days, any member of the Board of Directors may request that the policy be formally reviewed by the Board of Directors before the policy is adopted as official ALEC policy.

C. A member of the Board of Directors may request a formal review by the Board of Directors. The request must be in writing and must state the cause for such action and a copy of the letter requesting the review shall be sent by the National Chairman to the appropriate Task Force Chair. The National Chairman shall schedule a formal review by the Board of Directors no later than the next scheduled Board of Directors meeting.

D. The review process will consist of key members of the Task Force, appointed by the Task Force Chair, providing the support for and opposition to the Task Force position. Position papers may be faxed or otherwise quickly transmitted to the members of the Board of Directors. The following is the review and adoption procedures:

- Notification of Committee: Staff will notify Task Force Chairs and the entire task force when the Board requests to review one of the Task Forces' model bills or resolutions.

- Staff Analysis: Will be prepared in a neutral fashion. The analyses will include:
  - History of Task Force action
  - Previous ALEC official action/resolutions
  - Issue before the board
  - Proponents arguments

- Opponents arguments

- Standardized Review Format: To ensure fairness, a set procedure will be used as the format to ensure the model bill/resolution has a fair hearing before the Board.
  - Task Force Chair(s) will be invited to attend the Board Review
  - Task Force Chair(s) will decide who will present in support and in opposition for the model bill/resolution before the Board.
  - Twenty minutes that is equally divided will be given for both sides to present before the Board.
  - It is suggested that the Board not take more than twenty minutes to ask questions of the presenters.
  - Presenters will then be excused and the Board will have a suggested twenty more minutes for discussion and vote.
  - All votes will be recorded for the official record.

- Notification of Committee: The Director of Policy will notify presenters immediately after the vote. If the Board votes to send the model bill/resolution back to the task force, the Board will instruct the Director of Policy or another board member what to communicate.

E. The Board of Directors can:

(1) Vote to affirm the policy or affirm the policy by taking no action, or
(2) Vote to disapprove the policy, or
(3) Vote to return the policy to the Task Force for further consideration providing reasons therefore.

F. Task Forces may only undertake educational activities that are based on a policy statement, model bill or resolution that has been adopted as official ALEC policy, unless the Task Force votes to undertake the educational activity, in which case the educational activity is subjected to the same review process outlined in this Section. It is the responsibility of the Task Force Executive Committee to affirm by three-fourths majority vote conducted in accordance with Section VIII that an educational activity conforms to a policy statement, model bill or resolution.

X. EXCEPTIONS TO THE TASK FORCE OPERATING PROCEDURES.

Exceptions to these Task Force Operating Procedures must be approved by the Board of Directors.